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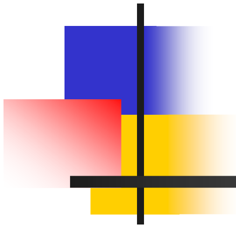


Supporting Individuals with Psychiatric Disorders and Developmental Disability-Intellectual Disability

Method

- Overview of psychiatric illness
- Each major category of illness with typical treatment
- Approach to supporting each individual is guided by the category of illness

What is psychiatric illness vs. behavior?

- Illness suggests that there is some suffering, lack of coping skills, mood or anxiety symptoms, mental processing problems.
- Behavior suggests self-control and planning, manipulation, although “behavior” is typically a response to overwhelming stress

What are some symptoms of psychiatric illness?

- Changes in behavior
- Changes in mood
- Changes in appetite and sleep
- Withdrawal from regular activity
- Changes in ADLs

What causes psychiatric illness?

- Genetic vulnerabilities
- Coping skills deficits
- Stresses that overwhelm our coping skills

How problematic are psychiatric disorders in DD?

- Major controversy in the field. Reiss, in a review of all studies in 1994, estimated 25% to 50%
- Others suggest a conservative estimate that 10% at all times have an active psychiatric disorder

Major Differences in Psychiatry between NIQ and DD

- Psychiatric Disorders in DD cannot generally be diagnosed and managed as one would an intellectually normal adult patient
- The developmental disability influences not only presentation of the psychiatric disorder, but the treatment and community support plan as well.

A comprehensive community support system

- There is International Consensus that individuals must be treated in the context of a system of professional and natural supports that has **crisis prevention** and **cross-system cooperation** with available mental health resources.

Behavioral Aspects

- It is essential that professionals trained in Applied Behavior Analysis be available to assess individuals and develop support programs.

Treatment Issues NIQ- DD

- NIQ
- medicine
- psychotherapy
- community supports AA, social agencies
- readings
- homework

- DD
- medicine
- psychotherapy
- behavioral supports
- community supports essential
- crisis prevention network
- homework-help

Psychotherapy

- Individual often necessary, CBT best record
- Group very helpful, PTSD
- Severe-Profound DD, may be of little value

Psychopharmacology in DD

- Overuse of antipsychotic medication
- Underutilization of antidepressants and anxiolytics

Branford 1997 UK, community

Antipsychotics	48%
Antidepressants	13%

Roberston 2000 UK community

- Antipsychotics 20%
- Antidepressants 4%

Hurley et al. 2003 % OPD

	NIQ	Mild	M-P
Antipsychotics	14	28	36
Antidepressants	40	28	26
Mood Stabilizers	08	25	31
Antianxiety	22	15	08

The Right to Psychopharm

- People with DD have a right to medicines that treat or ameliorate the symptoms of psychiatric disorders
- People with DD should not have medications offered in place of supportive care, psychotherapy, and behavioral support plans.

Diagnosing Psychiatric Disorders

Initial Psychiatric Diagnostic Exam

- N IQ
- establish relationship
- verbal exchange
- evaluate overall presentation
- discuss diagnosis and treatment plan

- DD
- relationship may be with “team”
- person’s verbal ability limited
- presentation may be atypical
- “team” treatment negotiation

Intellectual Distortion

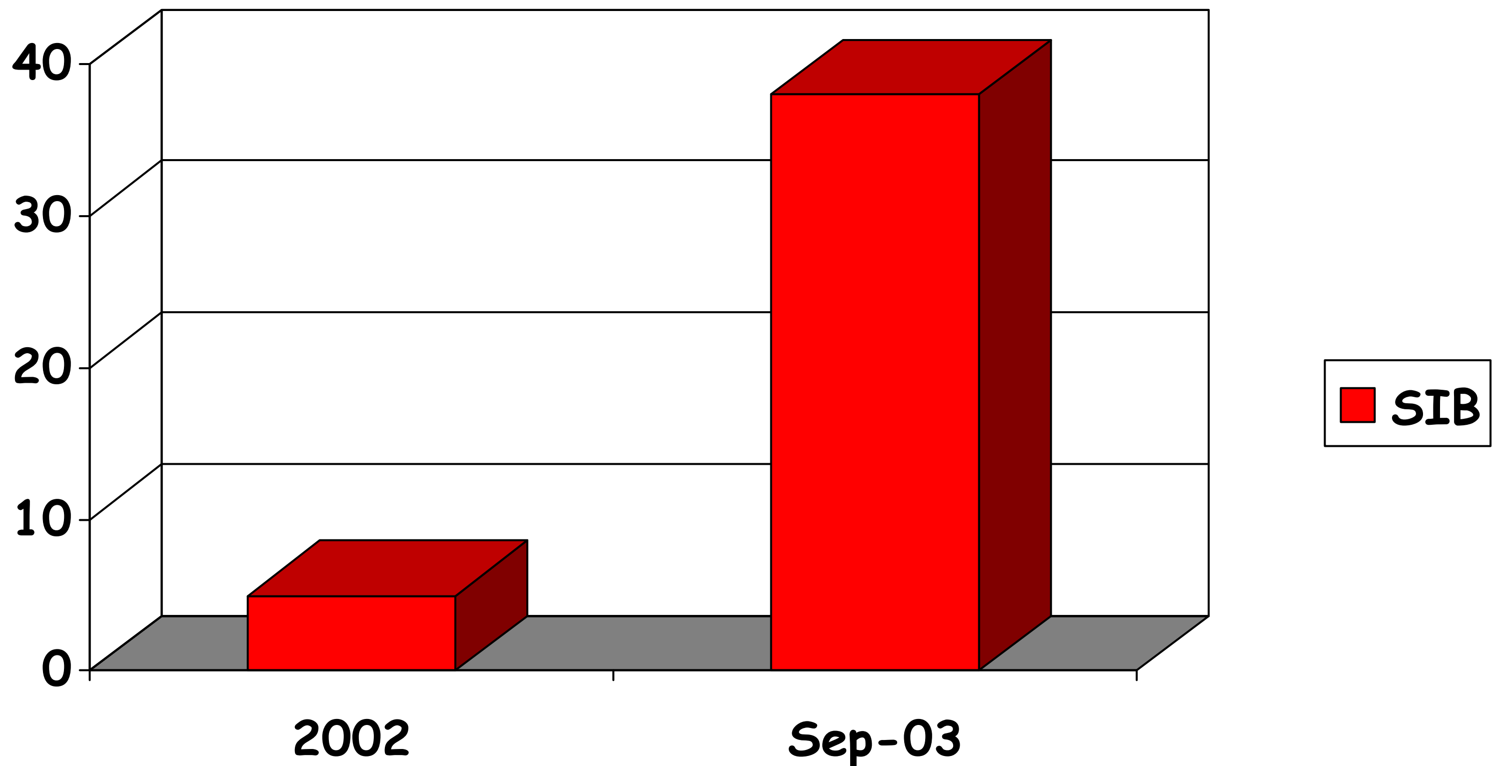
- Questions will be too complex and answers often meaningless
- Adjust questioning downward
- Do not accept even reasonable answers at face value
- "I idolized my grandfather. I don't know what idolized means." (32 yo male with Down syndrome)

Baseline Exaggeration

- Maladaptive behaviors that exist at a low rate and low intensity increase dramatically during a psychiatric illness, and become the focus of psychiatric treatment
- The behavior is a symptom--not the focus

Self-Injurious Behavior (SIB)

previous and 1st psychiatric appt



Cognitive Disintegration

- Due to the lack of cognitive reserve, people with DD, much like the elderly, may dramatically decompensate under stress, or with depression & anxiety
- Do not assume that a markedly abnormal presentation is associated with a psychotic disorder

Psychosocial Masking

- Individuals will experience symptoms within a developmental context
- Manic grandiosity may present in a person with DD – he might insist that he can drive a car

Answering “yes”

- People with DD often try to hide their disability by “yessing” people when they do not understand the question.
- “Yes, I hear voices all the time.”
- Questions must be open ended and checked for understanding

Deferring to Authority

- Individuals with DD often react to professionals as a child trying to please a teacher, or react to the authority figure with compliance.

Using third party information

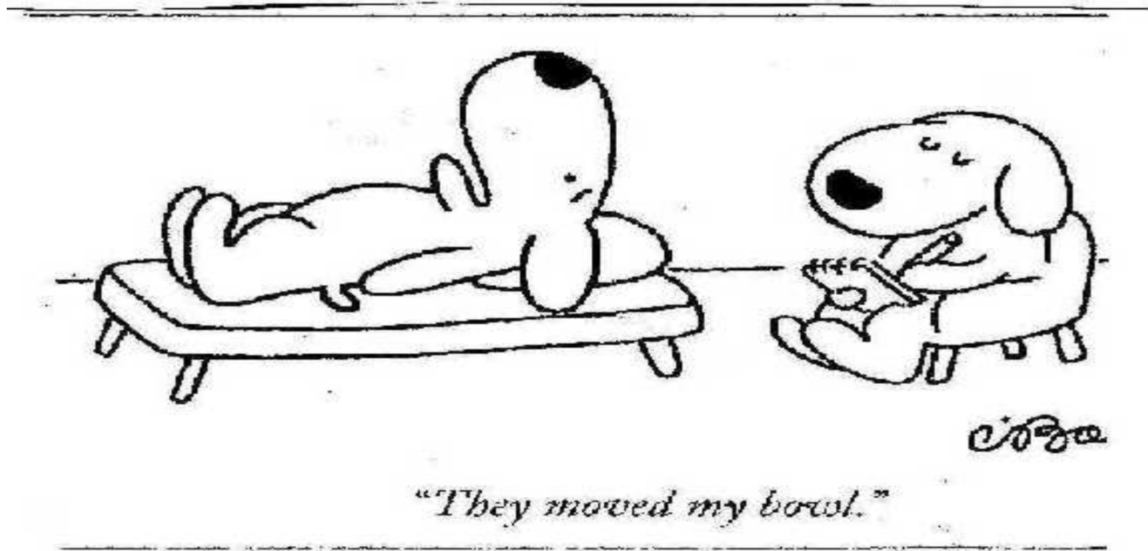
- Ultimately, like child psychiatry, clinicians must rely on third-parties as informants to obtain information for a complete assessment
- Informants are biased--they report what they can observe in behaviors; they may or may not know the individual well, may exaggerate or minimize symptoms

Direct Support Professionals & Family

- With rare exception, it is impossible to help individuals with developmental disability unless the support network is involved in diagnosis and treatment

The Role of Stress

"They moved my bowl."


"They moved my bowl."

When one suspects a problem…

- Identify the Stressor/ Historical- Individual / Family-Caregivers
- Determine if it can be changed
- Medication if necessary
- Work on adaptation

Typical Stressors - NIQ

- Financial
- Family, children, spouse
- Medical
- Developmental crises
- Societal worry

Typical Stressors –NIQ children

- School performance
- Friendship
- Family problems
- Family expectations & management

Typical Stressors – DD

Change in day-residence
New Staff
New Individuals
Turning 22
Medical Condition
Friendships

Typical Stressors- high DD

- Financial
- Marriage, children
- Jobs
- Interpersonal
- Independent living

- May be the most common mental illness
- Most cases go unrecognized and untreated

Understanding depression

- Is horrible, internal, “black mood”
  Beck’s Cognitive Triad
- Negative view of self
- Negative view of world
- Negative view of future

Depression

- Typically linked to premorbid personality and coping skills
- May be normal reaction to loss
- Irritable, angry, agitated
- Withdrawn, low energy
- Lack of motivation, enjoyment a major barrier

Major Depression-criteria

- NIQ
- Mood
- sleep, appetite

- DD
- Looks sad, angry, differences in activity level
- active, tantrums at dinner, stealing food

Major Depression-can have mood congruent hallucinations & delusions

- NIQ
- Lack of pleasure
- fatigue, energy
- feeling worthless
- concentration
- thoughts of death

- DD
- Refusing activities, isolating
- observing behavior
- "I'm bad."
- ?
- Thoughts past, loss

Diagnostic Criteria

- People with DD rarely meet full diagnostic criteria because they cannot verbalize their symptoms
- One must diagnose pts even if they do not meet criteria
- “clinical uncertainty” is pervasive in our field

Cognitive equivalents

- Think about the typical verbalizations and apply a DD model. For self-esteem, continual "I can't do that."
- Use psychosocial analysis-- apply DD model. For grandiosity, "I can drive a car." "I'm making lasagna."

Behavioral equivalents

- This is somewhat controversial, but has been used for years.
- Maladaptive behaviors that might be consistent with distress are substituted for criteria.
- Aggression = irritable mood

Behavioral equivalents

- Any maladaptive behavior might increase in frequency or severity during a mood episode or with chronic depression
- Self-injury might become more severe and frequent
- SIB increase = irritable mood

Mood and Normal IQ

- Irritable = behavior that is impolite, verbal insults, overreacting negatively to situations, social approaches, task demands-- slamming doors-"agitated depression"
- The person's view of life is taken over by the "black mood"—cognitive triad negative view of self, world, future

Sad mood equivalents

- Staying in bed, not wanting to do anything, letting go responsibilities, not seeking any social outlets- NIQ
- Withdrawal from activities
- No energy or excitement for the day
- Refusing activities or work
- Ignoring friends

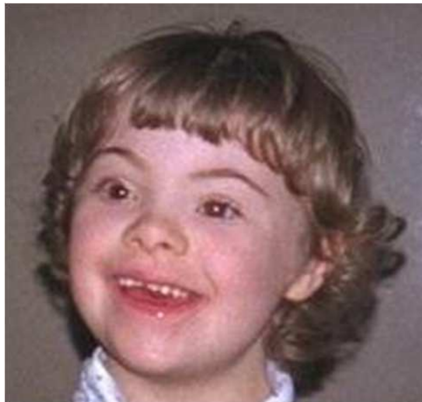
Appetite symptoms

- Largely ignored in DD unless severe
- Appetite-Wt can be easily monitored
- Refusal to eat, throwing food, acting up during meals might be an equivalent of appetite loss
- Stealing food and overeating might be increase in appetite

Sleep symptoms

- Largely ignored
- If up at night, data can be kept about insomnia
- If oversleeping and taking to bed, data also is available
- If awake in bed, no one may know, night staff-family ? checks

Down syndrome- high rate of depression, unusual features



Other behaviors

- Any bad habit may increase when depressed; emotional eating, compulsions, poor social skills will usually be worsened, lack of personal care or home care

Major depression vs adjustment disorder with depression

- Adj most common diagnosis, pt does not meet full criteria for MDD, typically sleep and appetite and concentration OK, and stressor identified***
- Treatment usually does not include medication and is aimed at addressing and/or coping with the stressor

Treatment MDD- Medicine

- Great advances in medicines, with many available, SSRI, Wellbutrin, Effexor, Remeron
- Mood stabilizers may help
- Lithium a consideration in difficult cases

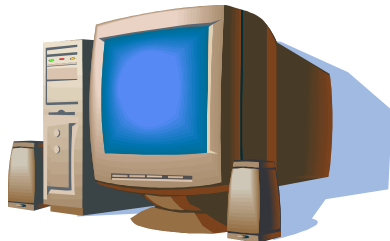
Depression: CBT--apply cognitive behavioral therapy

- Lessen the value of the stressor: de-catastrophize
- Increase positive feedback
- Increase pleasurable events
- Increase contact

Depression – needed supports increase contact

- Company – TV, game, walk, cleaning room
- DRO-DRA-DRI- DRP (differential reinforcement of the person) Interaction q 15 minutes

Increasing pleasurable activities- brainstorming



Increase Mastery

- Very important in NIQ treatment
- Can address competence: more chores, responsibility, feedback about competence
- Best to organize a special program

Treatment - Psychotherapy

- CBT has most evidence
- Appropriate for verbal, motivated mild ID
- Must involve caregiver system –with rare exception

CBT Psychotherapy – Ms. K

- Family psychotherapy
- CBT methods-- journaling positive activities daily, relaxation responses to stress, charts re: mastery
- Aggression remains present but it is improving
- SSRI + increase at menses

Ms. K

- Continues to need therapy because so many little changes cause regression
- On the other hand, she has learned to adjust to the many staff changes in her day and residential support system

Ms. K-CBT staff support

- Help with daily journal of positives
- Wall chart of ADL skills-”running to win”
- Daily chart of happy behavior vs bad behaviors (aggression)
- Increase in pleasurable activities

CBT- HOME ASSIGNMENTS

- THIS IS A LOT OF WORK

Mr. L MDD 45 yo male, Mod MR

- After best friend suddenly died had MDD with insomnia, withdrawal, isolation, lack of appetite, and vomiting– which was the complaint
- Had vomited in the past (psychogenic vomiting)
- Wt loss 40 lbs.

Mr. L MDD 45 yo male, Mod MR

- Antidepressant
- Strong behavioral supports to supervise and stop vomiting, increase food intake by providing favorite foods which was complicated due to GERD (PCP forbid coffee his favorite food)
- Monthly staff meetings for above

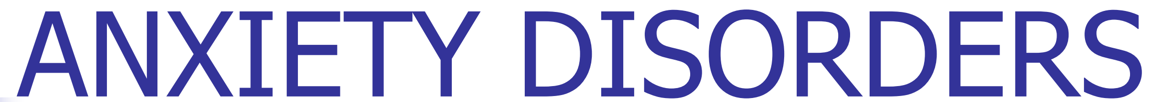
- 23 yo F mild ID
- Special ed, lived with family
- No work at graduation-depressed, anxious, nervous, pacing
- Coping cards-newspaper

New Housemate – Ms. M MDD

- Pt 45 yo female --history MDD-- became very depressed
- Mild ID, had worked, public transportation, group home since age 20, family rejection
- New housemate was intrusive, disruptive, targeting her

New Housemate Plan- Ms. M

- More frequent psychotherapy
- Medication regimen considered already optimum
- Staff meetings: Additional staff, increase outings, separation from housemate



ANXIETY DISORDERS

- May be second most common mental illness in the population
- Linked to worry habits
- Linked to genetic vulnerability to overarousal
- Premorbid personality important

Anxiety

- Fearfulness, worry are essential features
- Avoidance, panic
- Seeming to obsess
- OCD

Williams syndrome – high level of anxiety disorders

- Reduce fear- address worries in small bits
- Exposure & response prevention
- Support in small steps
- Extra support, reassurance, pairing with pleasurable activities, rewards
- Riding panic attacks-deep breathing
- Sometimes medicine

Reducing fear, panic Ms. V

- Female, 40s, work failure, family
- Excellent community skills
- Panic dx, worries- competence
- Medication, SSRI, depakote, clonazepam, finally Effexor

Reducing fear, panic Ms. V

- Coping skills:
- I do a good job, everyone likes me, take my time
- Relax

Reducing fear, panic Ms. V

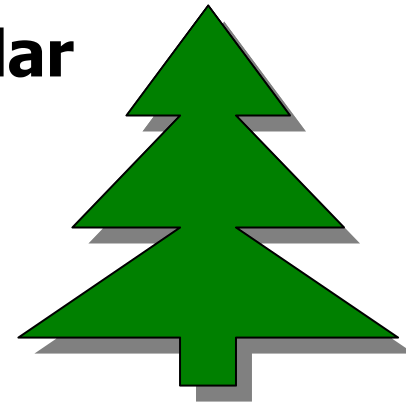
- Job #1 miserable failure
- Job #2, much better
- supportive staff, individual help re: anxiety, flexible, understood her capabilities

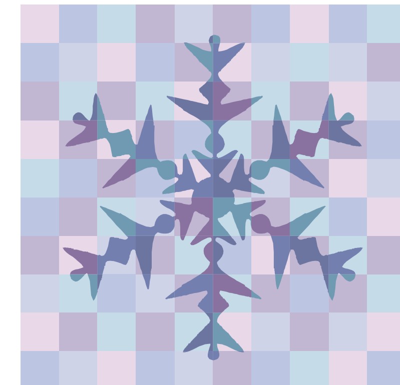
Relaxation- coping skill

- Verbal instructions
- Music, TV
- exercise

Holiday ADJ –brainstorming
Oct to March

- **Arrange schedule, use calendar**
- **Weekly activity**
- **Increase social contacts**
- **Arrange from Oct to Jan**





Medical problems –source of stress

- Accompany person to appts & hospital
- Prepare , verbally or words
- Help medical staff understand person’s level of ability
- Extra days, medication
- Staff stay in hospital

Bipolar Disorder- Manic Episode

- NIQ
- Period of expansive, irritable mood
- grandiosity
- little sleep
- pressure of speech
- flight of ideas

- DD
- Hyper behavior, more tantrums
- can fix a TV
- charts, reports
- more talk, interaction?
- ?

Bipolar Disorder-
Manic Episode

- NIQ
- Distractibility
- increase in goal directed activity
- excessive involvement in pleasurable activities

- DD
- ?
- Working more, doing more at home
- ?

Bipolar Dx treatment

- Medicine
- hospitalization
- provide stable schedules and psychotherapy

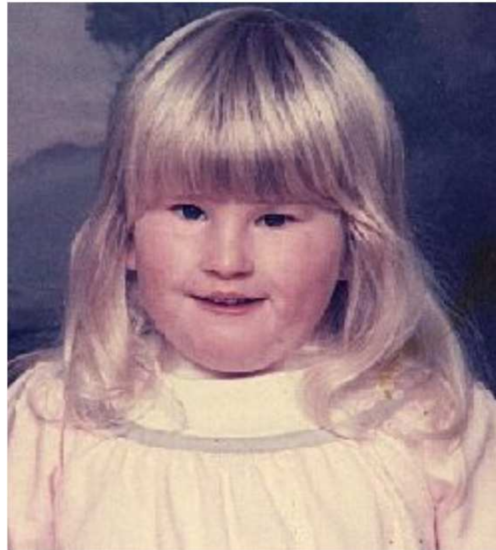
Bipolar dx; Ms J.

- 46 yo married female, bipolar hypomania. During manic episode, distorts reality, paranoid, confused, delusions of grandeur, imagines family arguments
- medicine, monthly appts, plus telephone and support system

Cook & Leventhal 1987 Bipolar DS

- 23 yo male Down syndrome. Manic, increased activity , impuslivity, little sleep, 20 lb weight loss. At night danced and sang. Grandiose delusion of being a famous musician. Dressed as a pop singer and demanded he be addressed as this person by all staff.

Prader-Willi syndrome



Prader-Willi

- Insatiable appetite for food
- morbid obesity & related conditions
- skin picking
- bipolar/ psychosis
- need for 24 hour supervision and food containment

Attention-Deficit Hyperactivity Disorder ADHD

- Types: inattentive, impulsive, combined
- Research showed low activity of frontal lobes --explains why stimulants work
- Hyperactivity, frequent academic problems, impulsive behavior, social impulse problems
- Boys more diagnosed

NIMH MTA study found

- Stimulants work the best when the doses were adequately high
- Parent training was essential in the best long term outcome

ADHD and Developmental Disabilities

- Probably the most undiagnosed condition
- “failure in school” is overlooked
- Hyperactivity and poor impulse control is assumed to be part of DD

AHDH

- If the individual is highly hyperactive and impulsive compared to age-peers, then this diagnosis should be considered
- This condition is linked to many behavioral problems due to poor impulse control

ADHD behavioral treatment

- Individuals usually respond well to charts, rewards, and structure
- Support staff and family must be helped to not respond negatively to the annoying impulsive behavior

Psychotic Disorders

- Schizophrenia
- Delusional disorders
- Brief psychotic disorder
- Psychotic disorder nos

Psychotic Symptoms Hallucinations & Delusions

- Hallucinations--sensory experience
- Delusions-- belief system
- loss of reality, catatonia

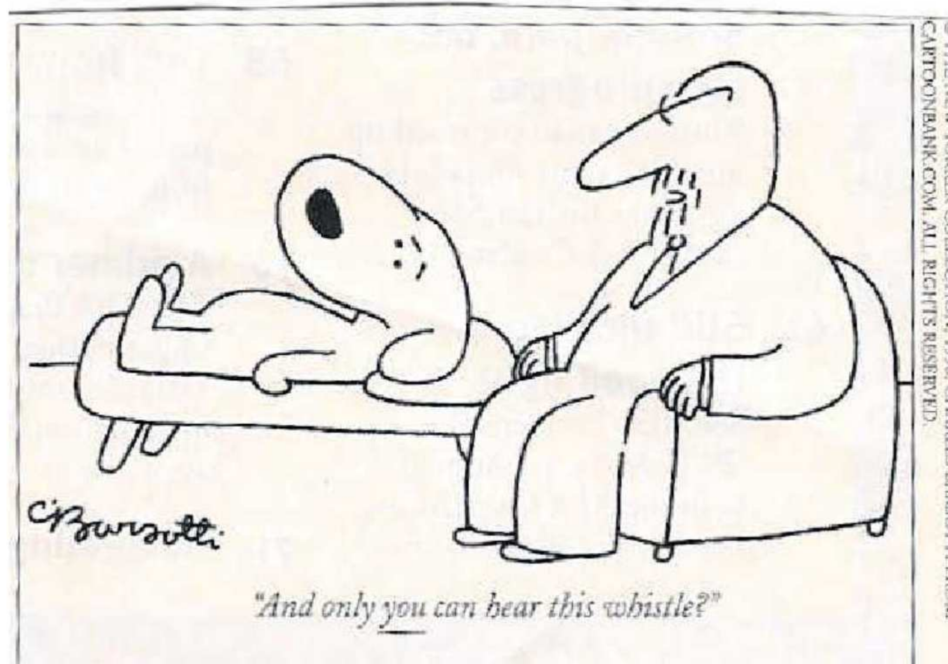
Hallucinations

- A hallucination is the perception of a sensory experience that is not real.
- It can be auditory, visual, or can involve smell, taste, or other somatic sensations.

Hallucinations & Delusions accompany many conditions

- Drug & alcohol abuse
- medical conditions
- medications
- stroke
- depression
- mania
- grieving

Hallucinations
"And only you hear this whistle?"



"And only you can hear this whistle?"

Delusions

- A delusion is a belief that is not true. Typically, a person holds a belief system that is not true, not just one event.

Delusions-fixed false beliefs

- simple or complex
- systematized or not systematized
- complete vs. partial (some doubt)
- Primary--not understandable
- Secondary--mood congruent,understandable

Delusions associated with acute brain injury

- Capgras- someone close is replaced by a double
- Fregoli- strangers are really a close person

Delusions associated with another person’s delusion

- Folie à deux
- Folie en famille

Schizophrenia requires 2 or more symptoms

- Delusions
- hallucinations
- disorganized speech (e.g. derailment)
- grossly disorganized or catatonic behavior
- negative symptoms: affective flattening, avolition

Hallucinations in schizophrenia

- Paranoid type: preoccupation with one or more delusions or frequent auditory hallucinations that are paranoid in nature

Schizophrenia: remaining subtypes

- Disorganized: disorganized speech, behavior, and flat or inappropriate affect
- Catatonic type: motoric immobility, waxy flexibility, stupor, or excessive motor activity, extreme negativneness, mutism, slow movement, echolalia or ecopraxia
- Undifferentiated; criteria A but not met for other specific subtypes

Hallucinations in schizophrenia 3 First Rank Symptoms

- **Audible voice that speaks aloud while the patient is thinking**
- **Voices give a running commentary on the patient’s actions**
- **Two or more voices argue with each other, often about the patient in the 3rd person**

Hallucinations-Command

- The patient is told to do something
- The patient sees something that instructs him to act

Schizophrenia

onset of disturbance --- Life Break

- **NIQ**
- **Delusions**
- **hallucinations**
- **disorganized speech**
- **grossly disorganized behavior**
- **negative symptoms**

- **DD**
- **May be simple**
- **may be unusual**
- **? Delayed speech**
- **different from past behavior**
- **different from past**
- **? Below IQ 50**

Coping with Schizophrenia

- Understand it is an illness
- Have a plan to deal with hallucinations
- Help person feel safe
- support and calming or redirection

Romme, Honig,Noorthoorn, Escher,1992 Br J Psychiatry 161:99-103 “Coping with hearing voices...

- questionnaire 450 Ss chronic hallucinations, 173 responded, 115 could not cope with voices, 97% in psychiatric care.
- 4 coping methods: distraction, ignoring, selective listening, setting limits
- Formed “Resonance”, a self-help group

Coping with Schizophrenia

- Sooth the person, agree that these voices are difficult to tolerate, stay with them, offer distractions e.g., going for a walk or playing a game, soothing activity e.g., having a cup of tea together.

Schizophrenia -coping with

- Hallucinations may be dangerous
- need emergency support plan-- e.g. someone telling the person to jump out a window
- Hallucinations may be associated with aggression

Single Delusional Disorder

- Without any other mental illness, a person may hold a single delusional disorder,e.g. paranoia, erotomania, etc.
- Many cases are associated with a preexisting disorder, e.g. schizophrenia or bipolar disorder -**Treat psychiatric illness if appropriate e.g. medication for bipolar dx**

Phenomenological aspects of monodelusional disorders. Munro A, Br J Psychiatry, 1991, 159: 62-64

- **5 types: persecutory, jealous, erotomanic, grandiose, somatic, other**
- **Once established, unremitting course, most never see a psychiatrist**
- **Tend to be isolated, poor interpersonal skills, introverted, many have a substance abuse history**

Erotomania -pathologies of love

- NIQ
- Belief one is loved by a movie star with no evidence, high status

- DD
- Belief one is married to a cartoon character
- Belief one is loved by the workshop director

Erotomania -vulnerabilities

- Social isolation, frequent in those who have never married, have no children, limited social networks
- Individuals with DD very vulnerable due to these factors

Erotomania -Delusions Supports

- Never disagree with the delusion
- Use distraction, redirection tactfully
- Identify the probable source or need for the delusion and try to meet this need
- Increase attention for other behavior (DRO)-secondary gain a major problem
- Treat underlying illness if appropriate

- Isolated man mild ID developed erotomanic delusion he married a cartoon character’s sister, acted upon this.
- Clearly depressed for years, treatment for depression did not resolve the erotomania

Ms. O

- 42 yo mild ID female, erotomania 5 years duration after boyfriend ended relationship (high status ID fellow). Delusion she was married to a famous singer, had 5 children, he visited her in the night. Acted upon this and told others. Drug therapy ineffective. Used comprehensive env program instead.

Case Reports: Collacott 1987

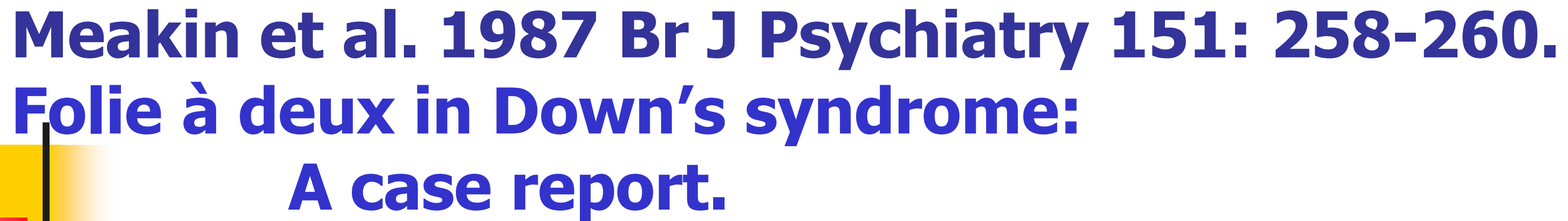
- **Female, mild MR, factory job age 15 to 23. She was shy, dependent on Mom, overprotected. She started to stay alone in the house, hoarding foods, hoarding personal items for 15 years. At age 44, she developed delusion that famous actor was in love with her. She reported hallucinations of him speaking to her. She was hospitalized & treated with anitpsychotics, her condition resolved.**

Collacott & Napier 1991
erotomania & Fregoli-like state

- **42 yo female Down syndrome--lived with parents until age 31, then placed in residential care.**
- **After death of father, “recognized” a bus driver as him. Saw father on TV programs. Then, erotomania about her bible instructor. Also, “recognized” a man as him later. Pt became grandiose, treated with thioridazine, slow mild improvement. Finally, she “saw” elderly man who was her father, believed he was buried outside her window, buried her papers from her father there. All symptoms resolved rapidly after this event.**

Folie à Deux

- A delusion develops in a person in the context of a close relationship with another person or people who have the already established delusion
- The delusion is similar to the established delusion



Meakin et al. 1987 Br J Psychiatry 151: 258-260.
Folie à deux in Down’s syndrome: A case report.

- 29 yo mild ID Down syndrome male. His 77 yo mother developed delusion that 2 women escaped from prison and were living in the rafters of her house. They were noisy at night and banged on the bedroom ceiling. She became increasingly withdrawn and frightened, and stopped her son from attending his day training center, and slept in the same bed with him for protection.

Meakin et al. 1987 **Folie à Deux**

- **The son confirmed his mother's delusions and stated that he heard the women's voices, that they swore at him whenever he flushed the toilet at night, told him his father was dead, and threatened to cut his throat if they caught him. Mother was treated with fluphenazine decanoate injections and community psychiatric nurse support. She recovered and her son's symptoms resolved without treatment.**

Brief Psychotic Disorder

- One symptom: delusion, hallucinations, disorganized speech, grossly disorganized behavior
- Can be with a marked stressor or not, with postpartum onset
- duration of at least one day and less than one month

Patient Mr. Adams

- 50 yo mild ID male-Female CR staff of many years said she was leaving for a new job.
- Hallucinations that he was having sex with her at night, in evaluation appointment he said he could feel her sexually at that moment……
- He was hospitalized, short treatment with low dose risperidone recovered-staff support plan

Psychotic Disorder NOS Varley 1984

- More than 1 month duration..
- **14 yo girl, sexual harassment problems at school. delusional relationship with TV character, hallucinations**
- **17 yo girl, bizarre behavior, silliness, auditory hallucination about people talking of her; delusions of an accident of 20 people outside her home. After psychosis cleared, revealed sexual assault**
- **16 yo girl, acute onset, said devil chasing her , auditory hallucinations, cutting Bible pictures. When cleared, revealed sexual assault.**

Ms. A

- 37 yo mild ID female, Down syndrome, her first MDD occurred after major medical trauma. Developed MDD and hallucinations of others talking about her and delusions about Baywatch. ECT finally resolved symptoms

Ms. B

- 57 yo mild ID Down syndrome female with Alzheimer’s disease. She developed paranoid delusions of being poisoned, the TV was speaking about her, hallucinations were visual and auditory. She responded to low dose risperidone.

Misdiagnosis of any patient…

- Understand the breadth of behavior and thinking among intellectually normal individuals
- Be educated about different cultural and religious beliefs
- Apply developmental delay model to those with intellectual disability

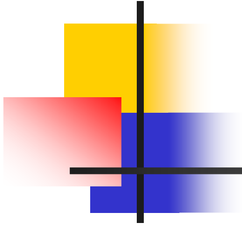
Misdiagnosis--Normal Population epidemiology--Hallucinations

- NIMH Epidemiological Catchment Area Program, 18,572 adults (1985)
- Lifetime 10% reported hallucinations

Hallucinations- Normal Population

- seeing, hearing, or feeling a deceased loved one--not studied but widely reported in literature on widows and widowers--as well by those who lost a child or close person to suicide
- visual hallucinations upon awakening-4%

Beliefs or Delusions?



- Gallup Poll, 60,000 adults, 1989
- "Are You Normal?"
- 25% reported ghosts, UFOs, etc.
- Cultural and religious beliefs vary widely

Pseudopsychotic symptoms Hallucinations & Delusions in DD

- monologue
- fantasy play
- imaginary friends

Monologue

- Person talks to himself out loud like a young child…oblivious of others, unashamed. May increase in frequency and character if upset, stressed, or during an illness.
- Families and staff mistake this for a hallucination

Private Speech -- Vygotsky

- All speech is open as it begins
- Toddler begins to subsume speech, make it private
- ADHD have a higher rate of open speech later
- We all talk out loud... normal problem solving, when upset, for fun...etc.

- 25 yo old mild ID male, hyperactive, very poor attention span, poor ADLs, Talked constantly…….. Mood stabilizer, antipsychotic eliminated with no ill effects-parents refused stimulants. Support and coaching of staff to deal with his activity level

FANTASY

Audience Survey

- Fantasy occurs in all of us--daydreaming
- Young children use fantasy a great deal in play
- Imagination seen in normal and in pathological thinking
- Daydreaming is a powerful psychotherapeutic tool + systematic desensitization

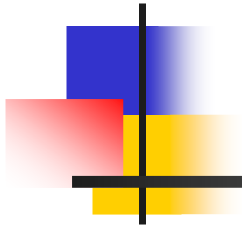
Fantasy or Hallucination -- Delusion?

- 40 yo mild ID Down syndrome
- family found “bizarre” drawings of “wonder woman” sex, comic books in room
- Has a “love life”
- ? normal population...

Fantasy Play

- 50 yo male, moderate MR. Daily would “play” in front of TV during his favorite shows e.g. “Hulk” or “WWF” acting as if he was in the program. He was dramatic, jumping about, yelling, etc.

Imaginary Friend or Hallucination?



Imaginary Friends in Children

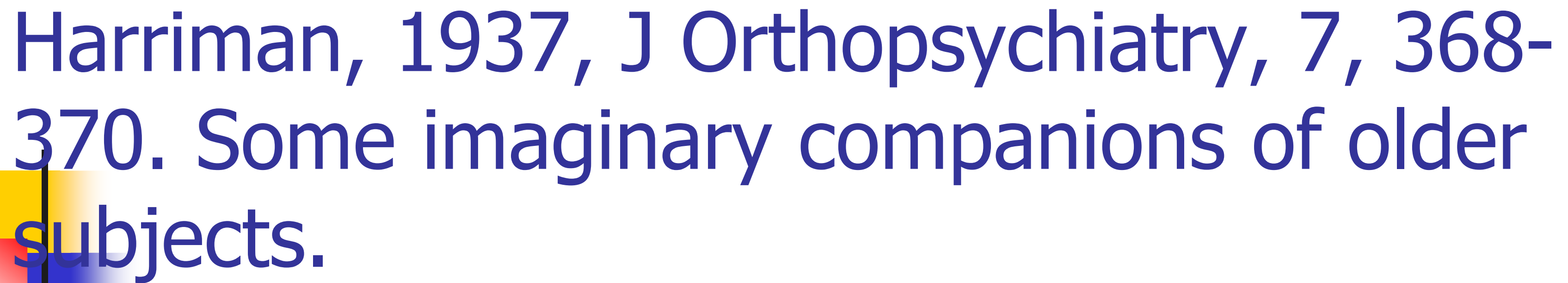
- 60% reported by parent---or is it really 100%?

Characteristics of Imaginary Friends

Audience quiz

Imaginary Friend supports

- powerful psychotherapy tool
- Do not confront-argue with the person
- Work with clinician for some negotiated control if needed
- See as normal expression of developmental delay



Harriman, 1937, J Orthopsychiatry, 7, 368-370. Some imaginary companions of older subjects.

- At Bucknell University, college students used imaginary friends as solace, to encourage

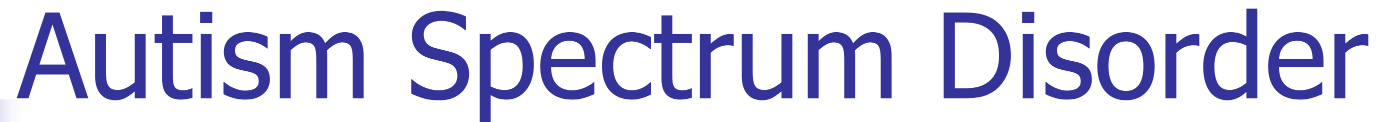
Imaginary Friends

- 60 yo man Down syndrome has many imaginary friends and talks with them very loudly every night in his room. Pt had MDD 10 years ago, still treated with risperidone and Zoloft

Imaginary Friends

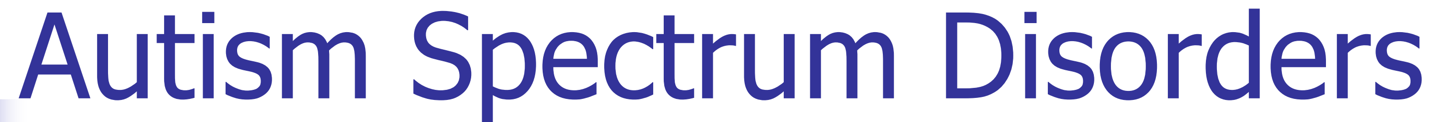
- 37 yo female had many friends (dozens) and talked to them constantly. Home staff finally worked a behavioral support program with her to cue “keep your friends in your room.”

Autism Spectrum Disorder



- Social connection --aloof or avoidance
- Poor processing of social information
- Limited social reciprocity
- Anxiety responses, OCD
- Soothing behaviors
- Self-injury or aggression
- Bipolar Disorder

Autism Spectrum Disorders



- Anxiety-use typical protocol
- Understand limitations imposed by social aspects
- Medicine is very helpful for some individuals