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Daniel Carlat, MD
Editor-in-Chief

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Learning Objectives

After reading these articles, you should be able to:

1. Discuss the diagnostic criteria for patients with intellectual disability (ID) according to DSM-5 standards.
2. Summarize some of the psychopharmacologic treatments and other interventions for managing symptoms in patients with ID.
3. Describe some of the key emotional regulation skills that can assist patients with ID.

Psychopharmacology for Patients With Intellectual Disability

Julie Gentile, MD. Professor of psychiatry at the Boonshoft School of Medicine, Wright State University. Project director for Ohio's Coordinating Center of Excellence in Mental Illness & Intellectual Disability.

David Dixon, DO. Clinical chief resident, Wright State University, Department of Psychiatry.

Dr. Gentile and Dr. Dixon have disclosed that they have no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Anne, a 23-year-old woman with moderate intellectual disability, comes into your office accompanied by a staff member of her group home. The staffer reports that Anne has been aggressive toward her roommate and has appeared more aloof over the last week. He is curious whether you can

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In Summary

- Although no medications are FDA-approved specifically for patients with intellectual disability (ID), medications such as antipsychotics, mood stabilizers, and antidepressants can be effective in treating irritability, agitation, and other related symptoms.
- It is important to involve families and treatment staff when prescribing medication for patients with ID due to communication challenges.
- Recognizing common disorders in patients with ID, such as anxiety, depression, and psychosis, can be difficult since the same behavior symptoms are often inherent in the condition.

Q & A
With
the Expert

Interviewing and Evaluating Patients With Intellectual Disability

Julie Gentile, MD

Professor of psychiatry at the Boonshoft School of Medicine, Wright State University. Project director for Ohio's Coordinating Center of Excellence in Mental Illness & Intellectual Disability

Dr. Gentile has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Psychotherapy is all about communicating, yet people with intellectual disability often have significant limitations in their communication skills, depending on their level of cognitive functioning. Is it possible for us to help these patients? If so, how? Julie Gentile, MD (www.juliegentile.com) has been looking at these questions for 20 years.



TCPR: Let's start with the basics. What exactly is the definition of intellectual disability (ID)?

Dr. Gentile: DSM-5 identifies it as an IQ of 70 or lower. Then there are ranges: mild, moderate, and severe/profound. Someone in the mild range has an IQ, generally, of 70 at the upper end and 50 to 55 at the lower end. The moderate range is 50 or 55 down to 35 or 40. Severe, on the upper end, is 35 to 40, and profound is about 25 or lower.

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prescribe a medication to prevent future episodes of aggression.

Prescribing psychotropic medications in patients with intellectual disability (ID) requires certain nuances in approach that may be unfamiliar to some psychiatrists. In this article, we'll discuss some aspects of assessment and treatment that you may find useful when you encounter and work with such patients.

Assessment

1. Ask about psychosocial issues.

We usually begin by ruling out psychosocial causes of the behavior, because these issues can often be fixed without resorting to psychopharmaceuticals and their attendant side effects. Here are some of the more common issues in my experience.

- Staff turnover at group homes is very high; they are often like family to clients, and when staff members leave, this can be a great loss.

- Any changes to routine across any setting will often trigger behavioral responses in ID patients with poorly developed coping mechanisms and lower tolerance for change.
- Reminders, or anniversaries, of significant life events (such as past traumas or losses) may be the cause of the current issues; it takes ID patients longer to process change, and psychotherapy may be helpful.
- Family members not visiting or coming less frequently, or a parent developing an illness, can result in less contact between patients and their support network.

In response to your questions, the staff member reports that there were no changes in Anne's family contact or routine. In addition, the group home changed the meal menu to items Anne prefers, increased her favorite activities, and reached out to family members, but nothing seems to have worked.

2. Ask about medical issues.

Because ID patients have difficulty communicating, they may have unrecognized medical symptoms affecting their mood and behavior.

- **Medication changes.** Patients with ID are more prone to adverse reactions from prescribed and OTC meds (especially antibiotics and antihistamines), which will often present as behavior problems.
- **Common medical conditions.** Ask about eating and drinking habits, bowel/bladder issues, and somatic complaints. ID patients frequently have behavior changes due to conditions such as GERD (gastroesophageal reflux disease), seizure disorders, constipation, infectious disease (UTI, sinusitis, etc), and dental conditions.

When you ask about any medical issues Anne may have had, the staff member says that a recent visit to Anne's PCP revealed no signs of infection or other medical problem that might have caused her agitation.

3. Assuming that there is a psychiatric cause of agitation, try to narrow down the underlying disorder.

- **Anxiety and depression.** These are very common and are often missed because the presenting symptoms are behavioral rather than the classic depressive/anxiety symptoms. A careful interview, while looking for observable signs of depression (eg, isolative behavior, crying, refusing to participate in favorite activities), can help.
- **Psychosis.** It can be hard to distinguish psychosis from general behavior change related to the inherent issues with ID, such as concentration and attention span problems, or low frustration tolerance/impulsivity. And because of communication issues, ascertaining the presence of delusions or hallucinations can be a challenge. We sometimes have success asking specific and concrete questions, such as:
 - Are you hearing people talk that you know or don't know?
 - Can you start or stop the talking?
 - Are you feeling someone touch your skin who you can't see?
 - Are your eyes playing tricks on you?
 - Does anything help? Is there anything that makes it worse?

During the interview with Anne, you ask her what happened with her roommate, and her reply is that "he told me to." The staff reports that Anne's roommate is female and that no males work in her group home. You notice that Anne seems to be periodically distracted throughout the interview, and you ask her if she knows who "he" is, to which she responds "no." Further evaluation reveals that Anne has started to hear whispers intermittently. Her eventual diagnosis is schizophrenia.

Psychopharmacologic treatment

The typical ID patient will already be on a number of psychotropic meds, so much of your job will be to evaluate current medications and judge which ones require adjustment. We typically

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ask family/staff for a timeline of medication trials. You'll want to know what happened when each medication was started, and when the dosages were changed. It's also useful to find out what was going on when patients were last doing well: Where were they living? What meds were they taking? Were they in school or working? It's important to find out, for example, that three years ago a patient was doing very well.

Sometimes a regimen will have been stopped for no good reason. One patient came in on 25 medications, and eventually we found out she was previously stabilized on risperidone and valproate. However, a peer told her that risperidone caused weight gain, so she stopped taking it, even though she had never gained any weight while on the drug. She was tried on many other medications (resulting in polypharmacy) and never attained stability since the discontinuation of risperidone. Over time, we restarted the prior regimen with great results.

In terms of FDA approval, there are no medications approved specifically for patients with ID; nonetheless, many of the medications used for irritability or agitation in autism and other similar disorders are often effective.

Antipsychotics

If a patient's issue is clearly psychosis, consider a low-dose second-generation antipsychotic (SGA) since these have lower risk of EPS. My go-to antipsychotics in this kind of situation include ziprasidone, aripiprazole, or lurasidone due to their better side effect profile, particularly regarding weight gain. We start at a low dose, and ask staff to carefully track behavior and specific symptoms. In our experience, it is best to put these instructions in writing on the doctor's order form that most treatment program staff bring to each appointment. For example, if you're starting a patient on aripiprazole 2 mg QAM, you'll want to write on the form: "Track sedation, energy level, aggression, and work attendance daily for 30 days." Since all written clinical orders are now documented, you can be assured that

these behaviors will be tracked and the results brought to the next visit. Based on the results, you can choose to maintain the treatment, or you can increase the dose or frequency of dosing—for example, if you see a pattern of decompensation at specific times of day.

As an example of how difficult psychosis can be to assess, we once treated a patient with low-dose lurasidone for schizophrenia for over a year. His behavior was under control, and he had no obvious psychotic symptoms, but he began to consistently refuse to attend his assisted employment program for no clear reason that he could verbalize. One day, he attacked his uncle. In talking to the patient about what happened, it became clear that he was paranoid that people were plotting against him, including a man at his workshop who resembled his uncle. This delusion was the reason for non-adherence to his work program. Once we increased the dose of the SGA, he started going to work five days a week.

You decide to offer Anne treatment with a slow titration of aripiprazole, starting with 2 mg daily for 1 week then titrating to 5 mg for 1 week, before having her return to your office. You ask staff to observe Anne for any common side effects (akathisia, sleep alterations, increased anxiety, GI alterations, seizure, etc) and document behavioral changes. Before Anne leaves the office, you order baseline labs (CBC w/diff, HgbA1c, fasting glucose, fasting lipids, CMP, TSH, ANA, RF, H. pylori, vitamins D/B12 and folate) and perform an AIMS screen. One week later, a telephone check-in with staff reveals that Anne has not had any demonstrable side effects to the aripiprazole, and that she appears to be slightly less distracted; additionally, she has not had any further incidents of aggression toward her roommate. You recommend that staff continue with the titration and follow up in another week as previously planned. When Anne returns to the office, she appears to be back to her baseline and denies bearing any voices in the last week. You recommend

continuing at the current dose and monitoring for any return of symptoms.

Mood stabilizers

Mood stabilizers can be quite helpful for agitation, and we will use valproate (our go-to) or low dose lithium (150 mg BID or TID; shoot for a level of 0.5 or 0.6 if possible to allow for variation in fluid intake). Oxcarbazepine isn't traditionally our go-to, but we do occasionally use it. For example, we had a 25-year-old patient with moderate ID and bipolar disorder. She hadn't tolerated antipsychotics in the past, and the family did not want her taking valproate or lithium (for various reasons), but they immediately agreed to oxcarbazepine 500 mg daily. It worked really well for her unstable moods and her obsessions. If mood stabilization is needed but the patient's risk is less imminent, consider oxcarbazepine, topiramate, lamotrigine, or gabapentin. Use great caution when tapering anti-epileptic drugs, even if there is no history of seizure in the past; we've had patients seize for the first time when stopping these medications.

If patients are already taking an SGA or a mood stabilizer that was previously effective but their symptoms have returned, try adjusting the timing before increasing the total daily amount. For example, in a patient taking valproate 1500 mg at bedtime with a return of aggression, try ordering 500 mg TID before titrating up. Some behaviors will respond to these changes, the passage of time may reveal other factors, or the patient may independently show improvement.

Antidepressants/benzodiazepines

For depression and anxiety disorders, we consider SSRIs first, and our top two choices are sertraline or escitalopram for their benign side effect profile and lack of drug interactions. If these aren't effective, you can try an SNRI or a novel antidepressant, but use extra caution with bupropion since it lowers the seizure threshold.

Be careful when using benzodiazepines; they can negatively impact

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TCPR: It sounds like there's overlap. Can absolute distinctions be made?

Dr. Gentile: Often, yes, because the diagnosis depends on more than the number. You also have to look at three domains. The conceptual domain is about evaluating skills such as language, reasoning, and memory. The social domain refers to empathy, interpersonal communication skills, and the ability to form and maintain relationships. And the practical domain centers on self-management, such as personal care, money management, and job responsibilities. When you consider these domains, it becomes easier to identify the severity of the ID. That's important because patients' categorizations determine whether they qualify for certain resources in the realms of community support and educational programs, for example.

TCPR: How common is ID? How likely is a psychiatrist to see patients with the condition?

Dr. Gentile: It's very likely that patients with ID will be incorporated into every practice setting. The prevalence of developmental disability in the U.S. is about 3.65%; it's about 2 times more common in males. Most patients—about 85%—fall into the mild range. Ten percent are in the moderate range, and that leaves 3% to 4% in the severe range and 1% to 2% in the profound range (<https://www.cdc.gov/ncbddd/developmentaldisabilities/features/birthdefects-dd-keyfindings.html>).

TCPR: Should we be giving brief IQ tests to some of our patients and assessing their conceptual, social, and practical domains to confirm our suspicions about their degree of ID?

Dr. Gentile: If patients are known to have ID, they typically are already tied in with a local board of intellectual disability, in their home county, and have already had IQ testing. Typically that testing is done by a psychologist who has special training in ID. The domains will have been evaluated, too. So by having access to the medical records, you'll have a very good idea of where patients falls in the ID range.

TCPR: Can you give us a brief thumbnail of what a person in each range might be like?

Dr. Gentile: Very likely, someone in the mild range—and again, that's most people with ID—will hold a supported employment opportunity. You've likely interacted with people having mild ID in the community; they may be employed at grocery stores or hotels, and often have a job coach. They'll have expressive language skills but will communicate in concrete terms. Someone in the moderate range typically has very limited language skills, and usually participates in specialized day programming once graduating from high school. Those in the severe/profound range will have very limited or no verbal capability, and in those circumstances, you'll use your observational skills and collateral data sources—the person who has brought the patient to your office—to a greater extent.

TCPR: How do you approach a patient depending on where they fall?

Dr. Gentile: It's best to communicate with all patients on their own terms. For example, for someone who has mild ID, use their mean length of utterance. If they are speaking to you in sentences or fragments that are six to eight words long, do the same with them. You also want to attend to memory and attention deficits and impulsivity. For some patients, briefer appointments that are more frequent might work better. Or you might opt for more lengthy appointments if patients have limited language skills and need more time to tell their story. No matter the level of disability, you can absolutely build an alliance with the patient quickly and accomplish everything you would with a neurotypical patient.

TCPR: What can you do to build that alliance?

Dr. Gentile: It may sound simplistic, but I always say to talk to the patient. It's very common for patients with ID to have been seen by prior psychiatrists and not to have been addressed during the appointment. Even if patients are nonverbal, it's still very important to talk to them because typically, their receptive language skills are much better developed than their expressive language skills. You should always assume that the patient can understand everything that's being said. So you introduce yourself: "Hi, I'm Dr. So-and-So. We are here today to figure out a way to help you feel better. We may be touching on some sensitive topics. Please let me know—give me a sign—if you want to move onto a different topic or you have something you need to tell me."

TCPR: So we shouldn't talk to the person who has brought the patient in and is also sitting in the room?

Dr. Gentile: It is important to "manage the triangle," so to speak, so you have to talk to and develop rapport with both parties. With luck, the caregiver is familiar with the patient and will be able to give you critical information during the session. And the more severe the ID, the more extensively you'll rely on that caregiver's knowledge. If the caregiver does not know the patient well or is not able to answer the questions you pose, ask if it's possible for someone more familiar with the patient to come for the next appointment. I recommend starting the appointment by talking directly to the patient, then going on to get information from the caregiver, and finally addressing the information with the patient to the greatest degree possible.

"It's best to communicate with all patients on their own terms. For example, for someone who has mild ID, use their mean length of utterance. If they are speaking to you in sentences or fragments that are six to eight words long, do the same with them."

Julie Gentile, MD

Expert Interview
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TCPR: Why is doing it this way so important?

Dr. Gentile: Even a patient with no verbal skills will immediately pick up on any disrespect from you. Remember, patients are usually not self-referred; they are mandated to attend treatment. They have no control in this process. That can absolutely affect their motivation, so they need to see your genuine desire to help so that they will buy into the treatment. This is crucial because most patients with ID come to us with some form of aggression—self-injurious behavior, physical aggression, verbal aggression. You want to be able to help them adopt an appropriate treatment plan that fits their needs.

TCPR: What do you mean?

Dr. Gentile: The therapist can't just be yet another person in the delivery care system. Usually, patients already have a case manager, a support/service administrator, several direct care staff members, a group home manager, maybe dozens of people in positions of authority that make decisions for them, and they often feel as if they have no control over their lives. Psychiatrists should distinguish their role as safe and trusted professionals who are committed to hearing patients' stories and helping create a treatment plan that focuses on the etiology of the behavior to address the underlying problem. If you talk to patients and you're honest about communication difficulty—"I'm sorry, I didn't catch that"—you're telling them you're interested in their story from their perspective. And their perspective will give you clues as to the function of the behavior, and from there you can arrive at solutions rather than being authoritarian.

TCPR: Can you give us some more tips on how to communicate with someone whose verbal skills are limited or nonexistent?

Dr. Gentile: There are so many ways to pick up critical information, to piece together an accurate diagnosis and a formulation for treatment. These include your observational skills, the patient's expressions of affect, and the patient's attention span and activity level. Also, many patients have iPads with apps designed for users with limited or no language skills. With some apps, the patient can touch the screen and the iPad will respond for them with pre-recorded common answers. Sometimes, as attending caregivers describe some of the behaviors they have observed, patients will "talk" by literally acting them out. They're listening, they're hearing every word, and they will sometimes recreate problem behaviors during the appointment. Many presentations are behavioral rather than verbal.

TCPR: For patients with mild ID who can talk—and these are going to be most of the patients with ID that we see—what else can we do besides speak to them in sentence lengths that mirror their own?

Dr. Gentile: Make sure to use cross-questioning techniques. Asking yes-or-no questions can be useful at times, but if patients have a trauma history, for example, they may answer "yes" to everything or "no" to everything as an artifact: something that has historically kept them safe. So if you say, "Do you sleep at night?" and the patient says "yes," you want to cross-question with, "Do you ever have problems sleeping?" That tells you whether you're getting accurate data. Multiple-choice questions present a different kind of challenge. If you're giving patients option A, B, or C, they will be very likely to choose C because with the memory issues in this patient population, that may be the only choice they recall. Double-barreled questions are another issue. If you ask, "Do you like your home and your staff there?" it's likely that you'll be given limited information because the patient can't handle two questions at once. It's better to ask one question at a time even though that takes longer.

TCPR: Any suggestions for how to ask about events that have occurred in the past? I assume it might be hard for ID patients to provide accurate information.

Dr. Gentile: Link questions about the past to events that your patient cares about. Salient events include birthdays, holidays, significant life events, and favorite hobbies. You can get those pieces of information from the caregiver and then use them during the questioning process. For example, if you're trying to get information about a prior event, anchoring it to "Bowling Night" will be more meaningful than asking about "last Tuesday."

TCPR: Can you give an example of how this actually plays out therapeutically?

Dr. Gentile: I had a patient in the mild range of ID—with expressive verbal skills—who had punched a hole in a wall. By speaking with him in ways that allowed him to communicate information effectively, I was able to learn that his favorite television show came on at 4 o'clock. A new group home manager arrived at his home to interview him just before that show began. When the patient asked for the interviewer to wait until after his show was finished, no one listened to him, so he punched the wall. We often just medicate because we don't take the time (or don't have the time because of managed care) to determine the etiology of the behavior and really hear patients' stories in their own words. The request from staff during the appointment is often, "We need more antipsychotics." There's so much unnecessary polypharmacy

DSM-5 Criteria for Intellectual Disability
(also known as intellectual developmental disorder)

1. The disorder began during childhood.
2. There are deficits in intellectual functioning, such as reasoning, learning, and problem solving.
3. There are deficits in daily functioning, such as difficulties with independent living and social skills.

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Psychotherapy for the Intellectually Disabled: The Skills System Approach

Julie F. Brown, PhD, MSW. Director of the Skills System at Justice Resource Institute and an adjunct faculty at the Trauma Center at JRI in Brookline, MA.

Dr. Brown has disclosed that she consults with agencies about implementing the Skills System Therapy Technique. Dr. Carlat has reviewed this article and has found no evidence of bias in this educational activity.

Patients with intellectual disability often have difficulty controlling their emotions, which is what leads to so-called “challenging behaviors.” These behaviors include a range of aggressive and impulsive interactions, such as assault to self or others, stealing, fire-setting, sexual offenses, and other problematic situations. These are, unfortunately, rather common among ID patients, and challenging behaviors are often associated with underlying mood disorders and psychosis, as well as with general difficulty modulating emotions.

Dialectical behavior therapy (DBT) has proven effective for helping patients to regulate emotions, with data for efficacy in borderline personality disorder, eating disorders, and others. My colleagues and I have adapted DBT specifically for ID, calling it the Emotion Regulation Skills System (Brown JF. *Emotion Regulation Skills System for the Cognitively Challenged Client: A DBT™-Informed Approach*. New York, NY: Guilford Press; 2016). In a pilot study of 40 patients with challenging behaviors engaging in DBT individual therapy and Skills System groups (DBT-SS), we found significant improvement in risky behaviors at both one-year and four-year follow-ups (Brown JF et al, *J Ment Health Res Intellect Disabil* 2013;6(4):280–303). These findings are encouraging and warrant further exploration of this technique.

In this article, I'll summarize the key components of the Skills System, highlighting its simultaneous sophistication and simplicity. Although the full technique is best used by therapists with special training, psychiatrists might find some aspects helpful in their brief sessions with these challenging patients.

Core skills and categories

There are nine core skills in the Skills System. The skills are broken into two categories: All-the-Time skills (which can be used by clients at all levels of emotion, even very intense levels), and Calm-Only Skills (interactive skills that are best reserved for times when the client is in emotional control).

All-the-Time Skills

1. Clear Picture
2. On-Track Thinking
3. On-Track Action
4. Safety Plan
5. New-Me Activities

Calm-Only Skills

6. Problem Solving
7. Expressing Myself
8. Getting It Right
9. Relationship Care

Rating feelings

We teach clients how to rate their feelings on a scale from 0–5, defining the levels this way:

- 0 = No feeling
- 1 = Tiny feeling (I can think clearly and talk and listen to others)
- 2 = Small feeling (I can think clearly and talk and listen to others)
- 3 = Medium feeling (I can think clearly and talk and listen to others)
- 4 = Strong feeling (I have fuzzy thinking and can't talk or listen to others)
- 5 = Overwhelming feeling (I am harming myself, others, or property)

Deploying emotion regulation skills

Depending on each client's emotions, we teach them to use specific emotion regulation skills to better cope with situations. We make things very concrete by teaching a “Recipe for Skills,” which helps clients put together specific skills chains for different situations.

1. **Clear Picture.** “Getting a clear picture” is how we describe the skill of mindfulness, and we break this skill down into the following six self-checking processes:

- Notice breath
- Notice surroundings
- Do a body check
- Label and rate feelings (using the 0–5 scale as previously discussed)
- Notice thoughts
- Notice urges

Example: Pat gets a Clear Picture when she thinks, “I see my housemate stealing my phone. I'm thinking, ‘He is a jerk.’ I am mad at a level 4. I notice my breath is shallow and my fists are clenched. I want to punch him in the face.”

2. **On-Track Thinking.** Once clients are aware of a negative urge, we teach them to “check it” and give it a “thumbs down” if it is off-track. The client then shifts the thought to one that is on-track.

Example: Pat engages in On-Track thinking when she realizes, “Punching my housemate is a thumbs-down. If I punch him, I will get in trouble. I need to move away and go to my room and do my coloring. If I talk to him now, it won't be good.”

3. **On-Track Action.** Taking an On-Track Action follows naturally from On-Track Thinking.

Example: Pat takes an On-Track Action by stepping away from the housemate and walking to her bedroom.

4. **Safety Plan.** If someone engages in an off-track action (eg, going near risk or doing something dangerous), a Safety Plan can help the person get back on track. We break down safety plans into various categories—as an example, we teach three ways to handle risk: focus on New-Me Activities, move away, or leave the area.

Example: Pat executes her Safety Plan when she moves away from the housemate and goes to her bedroom.

5. **New-Me Activities.** We distinguish four types of New-Me Activities: Focus, Feel Good, Distract, and Fun. Focus activities bring a person back into the moment and include things such as following step-by-step instructions, playing solitaire, or following a recipe. Feel Good activities are self-soothers, and include using the senses to enjoy pleasant things such as walking in a scenic area or using a pleasant-smelling hand lotion. Distract and Fun activities include watching TV, playing video games, drawing, reading, and talking to friends—anything to “turn the page” from what is bothering the person.
- Example:* Pat goes to the bedroom, puts on some music (a Feel Good New-Me activity), and folds clothes (a Focus New-Me Activity).
6. **Problem Solving.** This Calm-Only Skill entails taking a step back, defining the problem, and fixing it.
- Example:* On the following day, Pat asks to meet with her case worker to explore how to solve the problem related to her housemate stealing objects.
7. **Expressing Myself.** This Calm-Only Skill helps patients effectively share with others what’s on their minds and in their hearts. This sharing can happen face-to-face, on the phone, through video, or through sign language.
- Example:* While talking with her case worker, Pat expresses concern about feeling unsafe in the home when her housemate steals her things.
8. **Getting It Right.** This Calm-Only Skill improves patients’ ability to effectively ask for something they want from somebody else. The subskills of Getting It Right are: Right Mind, Right Time and Place, Right Tone, and Right Words.
- Example:* Pat consults with the case worker to set up a time to sit down and engage in Problem Solving about the housemate issue.
9. **Relationship Care.** This Calm-Only Skill helps the patient build on-track relationships and change those that are off-track.
- Example:* Pat decides to use Relationship Care skills to improve her relationship with her housemate.
- Practitioners may find aspects of the Skills System approach helpful when working with ID clients. For example, teaching a smattering of New-Me Activities can help clients regulate difficult emotions and can be a great adjunct to medications. By helping to put this skill set into practice, you will have a valuable tool when working with ID patients. You can help them remain calm and stay out of behavioral danger—and you’ll be able to see the results.

Take Home Points From This Issue

Tips for communicating with ID patients

- Talk directly to patients; they may not be able to talk much, but they can usually understand what’s being said
- Ask patients’ permission before discussing issues with their collateral contacts
- Use patients’ mean length of utterance—eg, if a patient communicates in sentences of 6–8 words, you should do the same
- To get more accurate information, use cross-questioning (ask about something in more than one way). Eg: Ask, “Do you sleep at night?” followed by, “Do you ever have problems sleeping?”
- Ask one question at a time, avoiding multiple-choice questions and double-barreled questions
- Link questions to salient events to help jog memory

Tips for psychopharmacology treatment

Items to assess for

- Psychosocial issues, such as staff turnover, changes in family contact, or other alterations in routine
- Medical issues, such as GERD, constipation, infections, dental conditions, or reactions to new medications
- Psychiatric disorders underlying challenging behaviors, such as anxiety, depression, and psychosis

Points to consult with staff/family about

- Establishing a timeline of medication trials
- Tracking specific symptoms and behaviors for several weeks after making medication changes

Specific medications to recommend for ID patients

- Antipsychotics: aripiprazole, lurasidone, ziprasidone
- Antidepressants: escitalopram, sertraline
- Mood stabilizers for agitation: valproate, lithium
- Adjunctive agents: alpha agonists, beta blockers, naltrexone

Psychotherapy tips for working with challenging behaviors in ID

Challenging behaviors are common in ID patients and may be related to underlying mood disorders, psychotic disorders, and general difficulty modulating emotions. They may include self-harm or assault, stealing, fire-setting, and sexual offenses. Suggestions include:

- Use DBT and skill systems training
- Have clients rate feelings
- Teach emotion regulation skills, such as mindfulness, on-track thinking and actions, a safety plan, and “new-me activities”

memory, cognitive, and respiratory function. They may cause a paradoxical effect in patients with ID, leading to states of disinhibition, which can increase impulse control or problem behaviors. To rule out a paradoxical effect, ask the patient directly, “Have you ever received a medication before a dental procedure or imaging and had the opposite reaction of what you were hoping for?” If using benzos, we prefer low doses of the longer half-life options, such as clonazepam 0.25 mg QD or BID.

Adjunctive agents

If antipsychotics and mood stabilizers have been tried but prove ineffective, intolerable, or only partially effective, our next step would be to prescribe an alpha agonist, beta blocker, or naltrexone. We use clonidine or guanfacine, but at a low dose, and we prefer to prescribe once daily, either in the morning or at 3 PM. Ask your patient

if symptoms are worse during daytime or evening hours, and have staff track progress for one month to gauge efficacy. If the medication is at 3 PM and only the evening hours are improved, you can add a morning dose. Most patients with ID have day programming, which is more structured. So, if you try a med in the AM and get good results, but the patient’s symptoms return in the afternoon, you can add a second dose to cover the remaining waking hours. If choosing a beta blocker, start low and go slow, using propranolol or betaxolol, and try to dose using the same timing schedule (3 AM and/or 3 PM). While naltrexone is approved only for alcoholism and opiate use disorder, there are also good data for a variety of impulsive disorders, including sexual aggression, skin picking, and overeating. Start with 25 mg, either 3 pm or 8 am, and you can go to BID, but don’t exceed 100 mg per day.

Other interventions

Don’t focus only on medications to fix everything—make sure to suggest other interventions too. There are multiple psychotherapeutic interventions that are modifiable for the ID population to treat mental health conditions. You can recommend a behavior support assessment for any problem behavior, and OT/PT/speech therapy/sensory assessments can assist with communication, functional limitations, sensory integration issues, and so on. Remember, you are not alone, but rather one part of a multidisciplinary team. Patients in their 20s who cannot communicate will get frustrated and will show us that they are struggling instead of telling us; don’t hesitate to order speech therapy, no matter the patient’s age. By asking about these extra interventions, you make the point that treatment will not be successful if it’s solely focused on medications.

As Freud said, “All behavior is purposeful.” Patients with ID *show* us their mental health symptoms; identifying them and providing effective treatment is an amazing experience. Imagine being the first person to connect with a patient and being able to help tell that patient’s story. Isn’t that what psychiatry is all about?

*Once Anne has been stable on ar-
piprazole for a month, you decide to
address her reluctance to talk to anyone
about her symptoms as they were evolu-
ing. You order a speech therapy evalu-
ation to evaluate any communication
challenges, and you recommend that
Anne start following up with a therapist
to learn to identify and express her emo-
tions more freely.*

Some Monitoring and Treatment Suggestions for ID Patients

- Do metabolic monitoring (HgbA1c, fasting glucose, fasting lipids) at least twice annually and more often if there are multiple medical or neurological conditions. ID patients may not be able to exercise, so they are at higher risk of metabolic side effects with medications such as olanzapine, quetiapine, and clozapine.
- Consider expanded lab work, including a standard intake panel (CBC, electrolytes, liver function test) as well as annual rheumatoid factor, ANA, vitamin levels (including Vitamin D, B12, and folate), and H. pylori (patients with ID have higher rates of H. pylori than the general population).
- Do an AIMS scale (or your favorite standardized screen for EPS) at least twice yearly, or more often if the patient has a diagnosed EPS condition, a history of EPS, or a muscular disorder such as cerebral palsy.
- Patients with ID are more vulnerable to neuroleptic malignant syndrome (NMS), and the fatality rate is higher in ID patients.
- Use extra caution with any medications that affect the seizure threshold (clozapine, anticholinergics, antihistamines, phenothiazines, bupropion, etc).
- Take into account difficulty with pill swallowing, as dysphagia is common; consider alternate preparations (liquids, dissolvables, etc).

**TCPR
VERDICT:** For ID patients, communication problems can make assessment challenging. Ask lots of questions to staff and family as well as the patient, and insist on plenty of symptom monitoring to determine whether your choice of medication is actually effective.

Expert Interview
Continued from page 5

(For more on psychopharmacology in ID patients, see the accompanying article by Dr. Gentile and Dr. Dixon). But when you hear a patient's story, you can provide support to the patient as well as education to the staff, and it's an amazing experience.

TCPR: Can you go through how this would work with someone who doesn't have expressive language skills? Even with observation and other techniques, it's hard to get a picture of how people who can't speak can tell their story in a way that allows you to help them.

Dr. Gentile: I had a patient with profound ID come in with a severe, extensive abuse history. I asked his permission for the caregiver to share that history with me: Did he feel safe in allowing her to share? He agreed by nodding. As she told his story of neglect, sexual abuse, and physical abuse, I could see as he was listening that he was curled up in his chair in the fetal position. After she finished, I looked at him and said, "I am so sorry that you had to suffer this type of abuse, and I can see that you are a survivor. You are here today allowing me to hear your story." And as I was talking to him, addressing him, telling him I was sorry, he literally put his feet back down on the floor. I went on to tell him it was an honor for me to work with him, that we were going to figure out a way to help him further recover from his trauma, and we would move forward and help him make his life look like what he envisioned for his own development. It is very important to communicate to patients with ID that they have the ability to recover from trauma; you must empower them and tell them you are not there to save them—they have the power to save themselves. You are there to support and facilitate.

TCPR: Wow, I'm sure many readers would be surprised about how much communication is possible with this population.

Dr. Gentile: I've seen nearly 4,000 patients with ID over the years, and it's a myth that you can't get good information from them. If you think these patients do not understand what's going on, all you have to do is observe. Violence against persons with ID is twice the rate compared to those without ID, while serious violent victimization is more than three times that of the general population—and these numbers only include reported crimes (Bureau of Justice Statistics Report, 2012). They're vulnerable for so many reasons: They can't report, people don't understand or believe them. And that critical piece of being able to tell their story, to process the trauma and move forward, often does not happen. Silence is the enemy when it comes to trauma, and it's our job to give voice to these stories to help these patients move forward.

TCPR: This has been fascinating. Any last thoughts?

Dr. Gentile: A lot of therapists will say, "I can't treat people with ID." They don't think it's possible. It *is* challenging. But if you talk to patients in their own communication style, if you identify yourself as having a completely different role from everyone else in their life and let them know right up front that this is a confidential relationship, that it's private and safe, that there are boundaries and they can decide what gets shared with their management team, there are potential great rewards. People with ID and mental illness may be considered the most vulnerable in our society, but in my opinion, they are also the strongest and most inspiring survivors.

TCPR: Thank you very much for your time, Dr. Gentile.

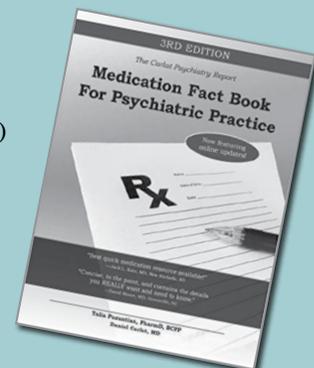
"Even patients [with ID] that have no verbal skills will immediately pick up on any disrespect from you. That can absolutely affect their motivation, so they need to see your genuine desire to help so that they will buy into the treatment."

Julie Gentile, MD

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Research Updates IN PSYCHIATRY

DEPRESSION

A Cautionary Consensus on the Use of Ketamine for Depression

REVIEW OF: Sanacora G et al, *JAMA Psychiatry* 2017;74(4):399–405. doi:10.1001/jamapsychiatry.2017.0080

Ketamine has become increasingly popular as an off-label medication for rapid onset treatment of refractory depression. Recently, the American Psychiatric Association convened a task force to review the data and come up with some recommendations. The task force reviewed seven double-blind, randomized placebo-controlled trials involving a total of 147 depressed patients.

In terms of patient selection, there are no clearly defined parameters regarding which patients are most appropriate for ketamine. Most evidence is in patients with depressive episodes without psychotic features, and the dose most often shown to be effective is 0.5 mg/kg given intravenously (IV) over 40 minutes. For perspective, the anesthesia dose ranges from 1 to 4.5 mg/kg IV. Anecdotally, the authors note that many ketamine clinics administer doses 2–3 times a week for 2–3 weeks and then taper,

depending on patient response. One study showed that doses given 3 times weekly were not more effective than doses given twice weekly. Common side effects after infusion include confusion, blurred vision, and poor coordination. Because approximately 30% of patients in three clinical trials experienced a spike in blood pressure over 180/100 mmHg and heart rates over 110 beats per minute, it's recommended to do basic monitoring (ECG, BP, O2 sat). Patients at a higher risk of complications (those with cardiovascular disease, those on other depressants, and elderly patients) should be treated at a facility equipped to manage cardiorespiratory events.

Some are reporting the use of lower or higher doses of ketamine, intranasal administration instead of IV, or take-home ketamine, but the authors could not find enough evidence in the literature to endorse these practices. For example, the authors describe trials using lower doses (0.1–0.4 mg/kg IV) or intranasal ketamine (50 mg/ml nasal spray), both of which seemed to show less robust efficacy (see *TCPR* February 2017 for one prescriber's anecdotal experience using intranasal ketamine).

Another unknown is how long to use ketamine. Response may be fast, but the studies reviewed by these experts showed relapse rates up to

nearly 90% just 4 weeks following the ketamine treatment. We have no long-term safety data either, and the authors share concerns of some of the known risks, such as cognitive impairment or abuse.

TCPR'S TAKE

Overall, the consensus statement makes one thing clear: We need more data. We recommend considering ketamine in severe, refractory, or suicidal depression without psychotic features, at a dose of 0.5 mg/kg IV over 40 minutes. Ketamine may also be useful in patients who are not good candidates for ECT. Though the rapid response is promising, the effects may be transient, and maintenance infusions may be required for some patients, similar to ECT.

Taylor Walker Noriega, PharmD candidate (2018). Ms. Noriega has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.



Intellectual Disability: Severity Levels

Severity Level	Percent of All People With ID	IQ Range	Notes
Mild	85%	50–70	Intact expressive verbal skills but communication in concrete terms; often in supported employment
Moderate	10%	35–50	Limited verbal skills; require specialized day programming
Severe	3%–4%	25–35	Very limited or no verbal capability; require assistance for all tasks
Profound	1%–2%	25 or lower	

CME Post-Test

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For those seeking ABPN Self-Assessment (MOC) credit, a pre- and post-test must be taken online at <http://thecarlatcmeinstitute.com/self-assessment/>

Below are the questions for this month's CME/CE post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning Objectives are listed on page 1.

- Your patient with intellectual disability (ID) presents with symptoms of depression and anxiety. According to Dr. Gentile and Dr. Dixon, which medication would be a recommended choice due to benign side effect profile and lack of drug interactions? (LO #2)

<input type="checkbox"/> a. An SNRI such as duloxetine	<input type="checkbox"/> c. An SSRI such as sertraline
<input type="checkbox"/> b. An antipsychotic such as aripiprazole	<input type="checkbox"/> d. A novel antidepressant such as bupropion
- Which statement about prevalence of developmental disability in the U.S. is true? (LO #1)

<input type="checkbox"/> a. Prevalence is about 3%–4% and more common in males
<input type="checkbox"/> b. Prevalence is about 3%–4% and more common in females
<input type="checkbox"/> c. Prevalence is about 5%–6% and equally common in both males and females
<input type="checkbox"/> d. Prevalence is about 6%–7% and more common in males
- Which of the following is an example of a core skill within the “Calm-Only Skills” category for helping patients with ID regulate emotions? (LO #3)

<input type="checkbox"/> a. On-Track Thinking	<input type="checkbox"/> c. Safety Plan
<input type="checkbox"/> b. On-Track Action	<input type="checkbox"/> d. Expressing Myself
- Your patient with ID has been taking a mood stabilizer that was previously effective, but his symptoms have recently returned. According to Dr. Gentile and Dr. Dixon, what optimal next step should a clinician try? (LO #2)

<input type="checkbox"/> a. Adjust the timing of the current dose
<input type="checkbox"/> b. Increase the total daily amount of the current dose
<input type="checkbox"/> c. Taper off the current drug while concurrently starting a low dose of a different mood stabilizer
<input type="checkbox"/> d. Taper off the current drug completely, then start with a low dose of a different mood stabilizer
- Your patient with ID is upset when a coworker stops by his desk and begins using his stapler without asking. Instead of losing his temper in the heat of the moment, the patient gets up and goes for a walk. This is an application of which of the Emotion Regulation Skills System skills? (LO #3)

<input type="checkbox"/> a. Relationship Care	<input type="checkbox"/> c. Safety Plan
<input type="checkbox"/> b. Problem Solving	<input type="checkbox"/> d. On-Track Action
- According to Dr. Brown, a patient with ID should be careful to apply the “Clear Picture” emotion regulation skill only when feeling emotionally in control. (LO #3)

<input type="checkbox"/> a. True	<input type="checkbox"/> b. False
----------------------------------	-----------------------------------
- Your ID patient with psychosis also has diabetes and is overweight. According to Dr. Gentile and Dr. Dixon, which antipsychotic has a better side effect profile regarding weight gain? (LO #2)

<input type="checkbox"/> a. Olanzapine	<input type="checkbox"/> c. Clozapine
<input type="checkbox"/> b. Ziprasidone	<input type="checkbox"/> d. Brexpiprazole
- Which of the following statements is true about people with ID? (LO #1)

<input type="checkbox"/> a. About 65% of people with ID fall into the mild DSM-5 category
<input type="checkbox"/> b. Most people with ID in the moderate DSM-5 category have very limited language skills
<input type="checkbox"/> c. Violence against people with ID is twice the rate compared to those without ID
<input type="checkbox"/> d. The sole determinant in qualification for educational resources for a person with ID is IQ range

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This Month's Focus:
Intellectual Disability

Next month in *The Carlat Psychiatry Report*: Retirement

Note From the Editor-in-Chief

Greetings to all our subscribers! Thank you for supporting our publications. As Editor-in-Chief of *TCPR*, I'll always be here to ensure you get independent and practical content with each issue.



In this month's issue, we cover a surprisingly neglected topic in psychiatry: How do we interview and treat patients who are intellectually disabled? Personally, when such patients come into my office, I feel at a loss: They are often accompanied by group home staff bearing a stack of forms for me to fill out, and it's not clear how to approach communicating with patients whose verbal skills are limited. I decided to get some advice, and what better way to do so than to find the country's best experts to help create a dedicated issue on the topic? The guidance they offer has already helped me in my practice, and I hope you'll find it useful too—let me know either way. I always love to hear directly from subscribers, so feel free to email me with your thoughts at dcarlat@thecarlatreport.com.

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