The Dual Diagnosis:

Mental Retardation and Mental Illness

A Guide for Caregivers

John J. McGee

James Glick

Preface

This guidebook is meant to provide an overview of the diagnostic and intervention challenges involved in helping persons with mental retardation and mental illness. It is intended to enhance the videotape <u>The Dual Diagnosis: Mental Retardation and Mental Illness</u> by providing additional information related to helping persons with complex needs. It also calls on caregivers to focus on the human dimension of the diagnostic intervention process and raises questions regarding current practices.

The dual diagnosis presents us with a unique opportunity to help those who are often the last to be served, the least likely to be served, and the most subject to punishment and restraint. Yet serving persons with these needs can yield profound insights into the very nature of the human condition, its paradoxical simplicity and complexity, and its revelation to us that all people long for equality and justice.

What is the dual diagnosis? How can we help people with these needs? These are the questions that we will explore in this booklet.

Mental retardation is a unique expression of the human condition, bringing along with it both gifts and special needs. The gifts are many--a simplicity in viewing life, forthrightness in emotional expression, authenticity and, often, an obvious and innocent hunger for affection. The human needs that it brings are well documented--slowness in thought processes, difficulty in verbal communication, hardship in comprehending abstract thoughts and feelings, and lowered defense mechanisms. Such allied needs also make the mentally retarded individual vulnerable to mental illness. Personal understanding of social situations is lessened. Reactions can be impulsive or inappropriately channeled. Expression of feelings can be extremely difficult. And diminished ways of protecting oneself can lead to frustration, sadness, and interactional difficulties. Indeed, up to 30% of the mentally retarded population have an allied mental illness at some point in their lives.

Why is this? It is due to both the very nature of retardation and society's responses to it. Those with mild and moderate retardation realize that they are different--segregated schools tell them this, sheltered workshops tell them, a life of poverty when working to become financially self-sufficient brings the message out clearly. Allied disabilities, which often accompany more severe mental retardation, also increase one's vulnerability through seizures, deafness, blindness, autism, and other phenomena, all of which make the world a more difficult place to enter into fully. Having only minimal language, persons with severe mental retardation often flounder in frustrated confusion. Programs frequently shuffle the individuals from one setting to another with insufficient regard for the human need of emotional stability and the unfolding of warm relationships. Many are subjected to programs and interventions that leave an emptiness in their being through a solitary focus on behavior modification or the acquisition of skills.

As is true with anyone, the entire range of mental illnesses can befall the person with mental retardation--schizophrenia, depression, manic-depression, personality disorders, and adjustment disorders, to name but a few--multiplying both diagnostic and intervention challenges. The presence of mental illness means much more than just observable behaviors. It implies an inner world in turmoil and represents emotional turbulence that often cannot be explained by the person who is experiencing it. It requires sensitive insight into that person's life-condition, which is often only obtained from significant others. It is diagnosed through this insight, plus inference based on a process of critical questioning, direct observations, and familiarity over time. For example, if John had been doing well at work and in his group home, why does he now refuse to go to work? Why is he losing weight? Why is he sitting by himself more and more? John might not be able to verbally respond to these questions, so professional caregivers have to know his history, speak with significant others, probe for possible causes, and only then make a diagnosis.

Normal Adaptation

As we reflect on the lives of the mentally retarded, we know that if they are given ongoing support and guidance that they will be well adjusted to their place in the family and community. Yet, because of their vulnerability, they are more frail than most. It is therefore critical to reflect on the nature of mental retardation, the fullness of each person, and their normal adjustment before considering the dual diagnosis.

> For example, Tom is a normal young man with moderate mental retardation. He lives, works, and plays in the community. He holds a full-time job, takes care of himself, and participates in community life. Yet he receives multiple forms of support without which his vulnerabilities would be like raw sores. Tom has a sense of humor and enjoys life. He is active in a self-advocacy program, is able to reach out to others, belongs to community groups, has a close relationship with his brother, and receives

> support from a local counselor who is more a friend and helper than a staff person. He lives in an apartment, gains meaning from religion, and has a feeling of freedom. Yet he also displays a simplicity in his understanding and processes information slowly. He likes to dialogue, but is unable to explore issues in depth. His life appears simple but full; dependent in many ways, yet as independent as can be.

Most persons with mental retardation are like Tom--well adjusted, well supported, and searching for life's meaning in their own way. But what might happen if his nearly hidden social supports are yanked from under him? How would he respond to change if not supported in the process? Others are sometimes even more frail than Tom--having predispositions to mental illness that are further exacerbated by the presence of mental retardation. External forces can militate against these individuals through burdensome stressors such as poverty, cultural prejudice, and familial difficulties. Internal forces, such as genetic or metabolic dysfunctioning, can make such persons more prone to mental illness.

Schizophrenia

One of the most common forms of mental illness is schizophrenia which is marked by hallucinations, incoherent thinking, odd beliefs, strange behaviors, catatonia, and flat or inappropriate affect. It often results in decreased skills and impairment of routine daily functioning.

Charlie has mild mental retardation and chronic schizophrenia. He lives in the community, receives support from an advocate, and requires occasional inpatient care when his symptoms re-emerge. He has just had a relapse, having attacked someone due to a command from what he calls his "bad self." Charlie has extreme trouble with women owing to such commands and his only option is to blind and deafen himself in order to exert some self-control--"holding down my strength on women."

His grin and laughter speak forcefully of disorganized thoughts. His language is odd, echoing words that only partially make sense. His acts arise out of what he describes as "meanness" toward "ugly women," his urges coming on with hot flashes, his shakiness due to what he terms a "fection." As convoluted as they are, he can express his emotions. He feels that his "evil self" prohibits him from going to church since his evilness comes from the outside, that is until he developed his "religious foundation." Charlie attributes his aggression to being "voked" into fights, a struggle between his "good self" and "bad self."

Schizophrenia can take on many different forms. Charlie's oddities of behavior and verbal expression certainly suggest schizophrenia. His strange laughter and facial expressions speak of an emotional disconnectedness. His "mean" thoughts signal an ongoing delusion. Often, the "bad self," as expressed by Charlie, is a "voice" that transmits commands to the person. Although strange, it can be most forceful and real.

Alan's life is regimented by "little brown men" who breathe down his back and, with hard fists, send him back to the Civil War. His life is controlled by their leader, Genesis. Like Charlie, verbal

description aside, his flat affect, incoherent laughter, stereotypical movements, echolalia, and distanced relationship with his counselor speak of mass confusion and a disconnectedness from reality. The leader's iron fists order him to obey aggressive commands and leave him in a warring world that is all-encompassing.

These diagnoses of schizophrenia are fairly straightforward. However, among persons with severe mental retardation, it becomes more of a challenge since there is no language to describe their inner world and no verbal expressions of delusion. A diagnosis has to be made from personal knowledge, sensitive observations, and clinical interpretations. External behaviors, such as withdrawal, aggression, or self-injury, have to be interpreted as their "voices." John is a young man with schizophrenia and mild mental retardation. He is has been subjected to restraint due to self-injury. He has a melancholy affect and an inability to reciprocate interactions. He had functioned at a moderate level of mental retardation prior to early adolescence, but began to change around age fourteen. His speech is now severely impaired. His ears and chin are stigmatized by scars through constant picking and rubbing, and his head has patches of baldness from yanking out his hair. These behaviors have no apparent cause. His life-condition consists of a drawing inward that, with sad eloquence, speaks strongly of retreat into a world of unreality. His self-restraint is akin to an attempt to grab onto reality, but this falls apart as the world around him fails to reach out. He has been bounced from one foster home to another, thereby making the world more difficult to understand. He finds more significance in hurting himself than in interacting with others. The blood on his shirt symbolizes the inner anguish he must feel and the meaninglessness that enshrouds his being. His flat facial expression signals a deep disconnectedness from those around him.

People who dwell in an unreal world--a world characterized by withdrawal, meaninglessness in relation to others, and eventual harm to self or others--need to discover new ways of being and learn new modes of interacting. Whether it be Charlie and his "mean self," Allan and his Civil War

adventures, or John with his self-destructive withdrawal, the intervention process requires that caregivers re-structure the world of these individuals, making human interactions more powerful than schizophrenia, and enabling feelings of union to emerge. The use of psychoactive drugs can serve as a supportive adjunct with which to quell the more raging symptoms. But beyond clinical issues, the mentally retarded need supportive living and working arrangements which are stable, consistent, and value-centered across their life spans.

Bipolar Disorder

Another mental illness commonly seen in persons with mental retardation is manic-depression--cycles of depression interspersed with periods of mania. During the depressive cycle, the person loses weight, shows decreased interest in activities, and generally slows down in every aspect of living. At the other extreme, the individual becomes grandiose, has flights of fanciful thought, and becomes exceptionally talkative. If the person has severe mental retardation, specific behaviors, such as stereotypical movements or aggression may significantly increase or decrease as nonverbal expressions of drive or withdrawal.

Jay is a young man with moderate mental retardation and a bipolar disorder. At the moment, he is hypomanic. He becomes fixated on sports and game scores. When approached by caregivers, he rapidly becomes aggressive. His language flits from one exaggerated topic to another; when asked how much he earns he answers, "395 dollars and 95 cents," then decreases it to 200, complains of poor sleep, and then grabs onto a stream of thought related to sporting events. When in the depressive phase, Jay has substantial weight loss, virtually stops talking, and withdraws from interactions.

The depressive phase can be seen in Edith--her sad affect, her slowness, her difficulty in communicating with others. This young mildly retarded woman is generally talkative and playful, but when in the depressive phase, she closes down and appears more disabled. When manic, she

becomes extremely aggressive, breaking furniture and hitting staff. Her cycles flow in and out with rapidity.

All people need to develop a feeling of human interdependence and those with bipolar disorders need it more than most. They merit tolerance and ongoing support. The manic phase can bring out the worst in caregivers since the perception is often, mistakenly, that "He should know better..." or "She is just manipulating us..." When in the depressive phase, the retarded person is often forgotten by caregivers, since so many storms have been weathered. Our interactions should be warm, authentic, and understanding, regardless of the phase. Our counseling should be frequent, supportive, fall within the flow of their daily living, and in tune with their "phase." It should be direct and value-centered--helping them enter into friendship and companionship rather than submit to obedience. Adjunctive support through appropriate psychoactive medications should also be given and monitored. Edith and Jay, like the others whom we have seen thus far, need to be "put back together" by learning to interact, to reach out, and to both receive and reciprocate human affection.

Depression

Another common form of mental illness is that of depression, an affective disorder that is both devastating and demonstrative of the full sentient nature of persons with mental retardation. The very nature of retardation makes depression a common, yet often overlooked, phenomenon.

Bernie is young man with moderate mental retardation whose parents died three years previously, causing him to fall into a deep depression that left him uninterested in life. He lost 30 pounds, no longer slept well, locked himself in his apartment, and centered his life on his cat, Tiger. He is a kind man with feelings of total loss. He keeps seeking reassurance from his counselor with the repeated refrain, "Is that really true, John?", a lament that demonstrates his search for meaning within a self-described state of "worry and shock."

Whether caused by the unexpected death of parents, as in Bernie's case, or other life changes, a mentally retarded person's world can cave in. And unless there is loving and ongoing support, depression's cold hand can tighten its grip until all hope is strangled. Fear can become dominant in retardation's simplicity of thought, or what Bernie regards as a "being a little slow" and as "loosing your thinker."

Just as impacting, although much less recognized, depression can befall those with more severe mental retardation.

Michael is such a man. He also suffers from blindness and a major hearing loss. His trauma occurred when he was removed from his family home and placed in a group home due to the ill health of his father. For him, this change was incomprehensible and equal to a break from life so severe that he required custodial care. He lost his minimal language, his daily living skills, and almost totally withdrew from reality. Interactions with others lost their meaning. His father and caregivers described him as being on the brink of death. He still bears a sad facial expression and is unable to initiate or engage in the simplest social interactions. He refuses to eat and has lost substantial weight.

Michael and Bernie, like others afflicted with depression, need an instillation of hope, a renewed feeling of life, and a re-introduction into the spirit of companionship. Caregivers need to assume the vital responsibility of finding ways to re-engage the retarded person's spirits by giving ongoing and unconditional valuing, and by eliciting reciprocal human interactions.

Paranoid Personality Disorder

Other mentally retarded persons develop paranoid personality disorders marked by a general dissatisfaction with life. Their days are filled with complaints and anger, and they rarely find any meaning in relationships other than the fear of exploitation.

Stan almost always prefers solitary activities. He views others as deliberately threatening and demeaning and is suspicious of almost everyone. The slightest problem becomes a huge aggravation and his life seems to consist of whining anger and continuous grudges. He is not happy where he lives and works, has little desire for social or sexual experiences, and appears aloof and cold. As a result of his running away, he is either homeless or bounced from one institution to another. When not satisfied, he becomes aggressive and his constant yelling drives his caregivers away. Or, they respond with simplistic token programs--no complaints earn him one cigarette per hour.

The question of how to help Stan centers first on healing his spiteful wounds and then helping him to re-structure his life. His caregivers have to learn not to focus on bestowing cigarettes, but on unconditional valuing; ensuring him of maximum community integration while protecting him from exploitation. They need to facilitate feelings of safety and security, encourage and effectuate participation, and teach him to accept and reciprocate affection.

Because his paranoia needs to be directed away from whining toward a feeling of trust and friendship, his caregivers must learn to respond to his dissatisfaction by helping him define his life as good where it is good and to correct it where it is bad. This redirection of feelings involves describing his reality to him, describing his buddies, taking his complaint of loneliness and accepting it, helping

him to deepen old friendships, and putting his needs into a new framework. He must be assisted in putting his life together rather than just complaining about it, or as his caregiver says, "to do stitchin' instead of bitchin'."

Antisocial Personality Disorder

Another frequent diagnostic category is that of the antisocial personality disorder. Men and women with this diagnosis have typically demonstrated conduct disorders, such as school truancy, cruelty to others or to animals, psychosexual disorders, and fire setting, since childhood or adolescence. And, in their young adulthood, such behaviors become fixed patterns of lying, aggression, and impulsivity that breaks social norms. These individuals often become involved in the justice system due to criminal acts.

Marty has had such a life history. Brought up to steal groceries and a "troublemaker" in school, he has been picked up by the police for setting a houseparent's car on fire. His "I could care less" attitude speaks of the lack of remorse so common in persons with this mental illness.

Robin has a similar life story. She has a recent history of molesting children, alcoholism, promiscuous sexual behavior with adult men, and setting fires in order to get even with those who scorned her sexual advances. As with Marty, she skirts the truth and places blame on others; she does no harm, others are at fault. Although possessing many skills, she, like Marty, will require long term care and a supportive structure. Caregiver interactions will have to be firm, but warm, enabling community integration while ensuring community protection.

The issues to be dealt with in these instances are many. Clinical problems involving psychosocial disorders, alcoholism, and arson will have to be addressed, as well as structural issues related to living and working. Persons with an antisocial personality disorder challenge every social service system--foster homes, group homes, institutions, and prisons. They are often unwisely grouped together in locked, fortress-like facilities where they are controlled, modified, released,

and eventually returned. Although skillful, they need life long support, guidance, and supervision from multiple social service systems--mental retardation, mental health and, often, the courts.

Conduct Disorder

Of course, the earlier the diagnosis and intervention, the better. Children and adolescents with a conduct disorder display a persistent pattern of conduct which violates the basic rights of others and breaks major societal norms relative to their age. Physical aggression, property destruction, and covert stealing are common.

Larry has a conduct disorder that is rapidly developing into a major psychosexual disorder. He began by fondling dogs, cats, and rabbits, but now directs his psychosexual energies toward women. He has lived a segregated life with few opportunities for appropriate socialization. No one has ever taught him "what's okay and what's not okay to do." His moderate mental retardation brings with it a simplicity of comprehension and need for moderation; for Larry, "teasing" can easily become sexual aggression, not because of malice, but because of ignorance.

Caregivers need to be acutely aware of the level of understanding of individuals like Larry. The more concrete the demands, the better; the more demonstrative, the clearer. Larry displays a certain innocence and even ignorance about how to interact with others. For him, touching women on the knee is his way of expressing interest.

Randy provides a good illustration of the need for concreteness. He has a conduct disorder similar to Larry's and an evolving personality disorder. If caregivers try to use formal language with adolescents like Larry and Randy, such individuals will be doomed to ongoing ignorance and deteriorating behaviors. If the counselor tries to explain the appropriateness of what he calls "intercourse" only to have Randy think that "intercourse" means "in the car," then Randy is left empty-handed. He is only interested in "doing it...down there...playing strip poker...taking all his clothes off...telling girls they have pretty bodies," not understanding why he insults or frightens others. Randy,

like other adolescents, is searching for his identity and hungers for companionship, but does not know what to do or how to do it.

Caregivers need to focus on concrete, warm counseling along with ongoing community care and socialization opportunities rather than on the niceties of language.

Jimmy also is a good example of someone with a budding antisocial personality disorder. Having been bounced from one foster home to another and victimized by incest, this teenager with severe mental retardation will impose himself on any woman, his tickling turns into fondling and his fondling turns into aggression.

The secret is to be concrete in our interactions with these retarded individuals and to teach them new modes of being with others. Caregivers have to learn to express warmth coupled with tolerance, to offer redirection coupled with valuing, and to provide socialization opportunities coupled with authentic support. These are the caregiver responses that can pull the Jimmys, Robins, and Randys from the edge of psychosexual disorders. Critical to their psychosocial development is the establishment of a stable, guiding, and warm family setting which is strong enough to offer a model for decent human interactions.

Autism

An allied interactional diagnosis that can result in severe behavioral difficulties is that of autism. It is unfortunate that caregiving relationships are often marked by control instead of companionship, by fixating on compliance instead of friendship, and by enchantment with the diagnosis instead of empathy with the human anguish of the individual so diagnosed.

David is an adolescent with moderate mental retardation, autism, and a number of severe behavioral difficulties--biting self and others, hitting others, yanking out his teeth, biting out others' hair, and running away from caregivers. His "special" program consisted of shouting orders to him, such as "Hands down!" and, when he failed to obey, restraining him physically and spraying water

mist in his face. His facial expression is sad and empty, searching for meaning that cannot be found. He is tacitly defensive, unable or unwilling to attend to tasks, and only minimally verbal. He has an alternate means of communication, but this does not seem to help him express his feelings.

As is true of all human beings, David seeks a life based on safety and security. As caregivers, we need to center our interactions on valuing him not for his deeds, but for his being; not for rewards earned, since he earns precious few, but for his unconditional fullness as a life-companion. Even though he has autism, he needs to learn to reach out to others, participate with others, and begin a journey toward human companionship.

Anne Marie also has autism. Her world is comprised of restraint and punishment for severe self-injury and acts of aggression. She has the ability to verbally communicate, but her words are not sufficient to describe the depths of her anguish.

Regardless of diagnosis, aggression and self-injury in the mentally retarded frequently seem to bring out the worst in caregivers. Violence is met with violence. Leather restraints replace the embrace of warm arms. Helmets encase anguished heads. Shouts outlast the whispers of affection. David's violence to others or Anne Marie's violence to herself present unique diagnostic and treatment challenges. We must ask ourselves, what we can do to bring these individuals into the embrace of family and community life. New intervention strategies need to be explored, new definitions of intervention's purpose need to be created, and nonviolent means have to be found to signal a spirit of union. As caregivers, we need to recognize and be inspired by a culture that calls for the affirmation of human interdependence as the fundamental goal of caregiving and, indeed, of life itself. We need to decide to value others unconditionally so as to teach them that human presence signals safety and security, not restraint and punishment. We need to help the Davids and the Anne Maries learn that participation with others is inherently good; far better than the propensity to give up and

simply withdraw into an anguished inner world. We need to define the feelings of companionship as more central to the human condition than compliance.

Caregiving is first and foremost an expression of our values and beliefs. The caregiving process brings about mutual change, but its initiation lies with us. The central force is to give unconditional value to each person and redirect him or her toward new models of human interaction.

Childhood Disorders

Considering the roots of emotional development, it is clear that the processes of mental illness are manifold, yet at their essence rests human interactions. We begin with our perceptions of others as well as the options we then choose to help them structure their lives around bonded relationships, reciprocal interactions, and feelings of companionship. A reflection on the early expression of mental illness can give us deeper insight into this diagnostic and intervention process.

Many children have oppositional defiant disorders marked by immediate and spiteful behaviors, short-tempered interactions, and tantrums far beyond what might be expected for their developmental age.

Wayne, a seven-year-old boy, hates to go to school. He finds ways to deliberately annoy his parents and teachers, and despises doing what they ask of him. At the smallest demand, he trashes his bedroom or classroom, cries, and kicks. And when exceptionally angry, he spits in the faces of others. He is generally kicked out of school by mid-morning, but is as difficult at home as he was at school. His caregivers are warm and nurturing, but at their wits' end.

As caregivers, we have to find ways to intervene as early as possible by weaving new patterns of human interactions. We cannot remain preoccupied with decreasing maladaptive behaviors, but must go to the very roots of these children's emotional development in the hope that all children might learn to live together.

Chris, a child of poverty and segregation, has an attention deficit disorder involving fidgeting, distractibility, running about, shifting from one task to another, and difficulty in following instructions. He developed these patterns at an early age and, as he grows older, they have worsened until he has become the type of child who is often tied into his chair at school or slowed with tranquilizers. Our option is to teach him the meaning and power of human valuing and its reciprocation. In his case, this unconditional positive regard is expressed in the form of playful dialogue as well as assurances that he can both learn to accept ongoing valuing and return it to his caregiver. Once the seedlings of friendship are planted, the caregiver needs to assume the responsibility for helping him bring friendship to others.

Daniel is a child with a pervasive developmental disorder which is marked by many symptoms similar to those of autism but generally detected only after the 36th month. Daniel detests change and demands maximum caregiver attention. He has limited language and responds very poorly to any change in his routine. He has never played with another child, preferring to be by himself or momentarily with his teacher.

What one needs, the other also needs. Caregivers have to be astute in helping both of these children learn to live together--playing, sharing, and valuing one another. This means that we have to bring them together and teach them to share.

Conclusion

The initial purpose of intervention is to bring about a warm, authentic, and reciprocal relationship with the children or adults we serve. As caregivers, we need to teach these individuals that our presence signals safety and security. We need to effectuate human participation before fixating on skill acquisition. And, most critically, we need to ensure that the child or adult learns to accept and reciprocate human valuing.

The dual diagnosis has many faces and presents multiple challenges. Diagnosis requires a recognition of the wholeness of the person, the vulnerabilities that mental retardation brings to him or her and a knowledge of that individual's life history, which is most often obtained through dialogue with significant others. Treatment moves us far beyond any mechanistic view of the person with mental retardation; it mobilizes us to look upon each as a full person--mind, body, and spirit. In spite of the difficult interactional problems that mental illness presents, we need to see intervention as a process of mutual change--caregivers expanding and deepening their understanding of the various expressions of our human condition and persons with mental retardation learning to come together with those around them.

Perhaps Michael's kind caregiver best shows us what caregiving really is. Her words, her dialogue, her valuing literally begin to reach out to him as he hangs on death's edge.

One day she sat down with him and recited a story that she likes to tell her own child. Indeed, she imagined that Michael was her own brother. He did not seem to receive any meaning, but she continued. She repeated this refrain:

I'll love you forever,

I'll like you for always,

As long as I'm living,

My friend you will be...

As he seemed to sense a feeling of "life-is-worth-living," he began to snap out of his near catatonic state and, with the slightest smile, he repeated the refrain.

The dual diagnosis presents complex diagnostic and intervention challenges. Yet, at the same time, it offers us the opportunity to enter into the very essence of the human condition, to gain insight into its meaning, and to become more fully human through learning to value those who distance themselves from human interdependence.

PERVASIVE DEVELOPMENTAL DISORDER

ARISING IN INFANCY OR EARLY CHILDHOOD AND RESULTING IN

-- IMPAIRMENTS IN RECIPROCAL SOCIAL INTERACTIONS

-- A RESTRICTED REPETOIRE OF INTERESTS AND ACTIVITIES

-- STEREOTYPICAL REPETITIVE BEHAVIORS AND INTERACTIONS

-- ABNORMAL VERBAL AND NON-VERBAL COMMUNICATION SKILLS

-- DIMINSHED ABILITY IN IMAGINATIVE ACTIVITIES AND PLAY

AUTISM

ARISING IN INFANCY OR EARLY CHILDHOOD, A SEVERE FORM OF PERVASIVE DEVELOPMENTAL DISORDER THAT RESULTS IN

-- IMPAIRMENTS IN SOCIAL INTERACTIONS SUCH AS

- -- LACK OF AWARENESS OF OTHERS
- -- ABNORMAL OR MINIMAL PLAY
- -- EXTREME DIFFICULTY IN MAKING FIRNEDSSHIPS

-- IMAPIRMENTS AND ABNORMALITIES IN COMMUNICATION

- -- STRANGE EYE GAZE AND FACIAL EXPRESSION
- -- ABNORMAL SPEECH PRODUCTION
- -- ABNORMAL FORM AND CONTENT

-- RESTRICTED REPETOIRE OF INTERESTS

- -- STEREOTYPY
- -- PREOCCUPATION WITH OBJECTS
- -- DISTRESSED BY MINIMAL CHANGES IN ROUTINE

ATTENTION DEFICIT DISORDER

ARISING IN INFANCY OR EARLY CHILDHOOD AND WITH A NUMBER OF THESE SYMPTOMS FOR AT LEAST SIX MONTHS

-- FIDGETINESS

-- DISTRACTIBILITY

-- DIFFICULTY IN SHARING

-- BLURTING OUT COMMENTS INAPPROPRIATELY

-- POOR ATTENDING SKILLS

-- POOR PLAY SKILLS

-- EXCESSIVE TALKING

-- BOTHERING OTHERS

-- THRILL SEEKING

-- DIFFICULTY STAYING IN SEAT

-- SHIFTS FROM ONE ACTIVITY TO ANOTHER

-- DIFFICULTY IN TURN TAKING

-- SEEMS NOT TO LISTEN

CONDUCT DISORDER

ARISING IN CHILDHOOD OR ADOLESENCE AND WITH A NUMBER OF THESE SYMTOMS OR SIMILAR ONES FOR AT LEAST SIX MONTHS

-- STEALING PROPERTY

-- LYING

-- FIRES SETTING

-- CRUELTY TO ANIMALS OR PEOPLE

-- TRUANCY

-- PROPERTY DESTRUCTION

-- BREAKING AND ENTERING

-- FORCED SEXUAL ACTIVITY

-- USE OF WEAPONS

-- FIGHTING

OPPOSITIONAL DEFIANT DISORDER

ARISING IN CHILDHOOD OR ADOLESENCE AND WITH A NUMBER OF THESE SYMTOMS OR SIMILAR ONES FOR AT LEAST SIX MONTHS

-- TEMPER TANTRUMS

-- ARGUMENTS WITH ADULTS

-- REFUSAL TO FOLLOW SOCIAL NORMS

-- ANNOYING OTHERS

-- BLAMING OTHERS

-- TOUCHINESS

-- ANGRY AND RESENTFUL

-- SPITEFUL

-- USE OF CURSING AND SWEARING

ANTI-SOCIAL PERSONALITY DISORDER

-- EVIDENCE OF AN EARLIER CONDUCT DISORDER

-- IRRESPONSIBLE PATTERN OF BEHAVIOR SINCE AGE 15 INVOLVING

- -- INABILITY TO MAINTAIN A JOB
- -- DEFAULT ON DEBTS
- -- IMPULSIVITY
- -- "CONNING"
- -- IF A PARENT, LACK OF RESPONSIBILITY
- -- SQUANDERS MONEY
- -- PROMSICUITY
- -- LACK OF REMORSE

PARANOID PERSONALITY DISORDER

ARISING IN EARLY ADULTHOOD AND INVOLVING THESE OR SIMILAR SYMPTOMS

-- EXPECTATION OF HARM AND EXPLOITATION

-- QUESTIONS TRUSTWORTHINESS OF FRIENDS

-- BEARS GRUDGES

-- INTERPRETS EVEN BENIGN REMARKS AS THREATENING

BI-POLAR DISORDER

(MANIC-DEPRESSION)

ARSING IN EARLY ADULTHOOD AND INVOLVING ALTERNATING PERIOD OF MANIA AND DEPRESSION

-- DEPRESSIVE PHASE

-- DEPRESSED MOOD

-- LOSS OF INTEREST OR PLEASURE

-- POOR SLEEP PATTERN

-- SIGNIFICANT WEIGHT LOSS OR GAIN

-- FATIGUE

-- DIMINSHED COGNITIVE ABILITY

-- RECURRENT SUICIDAL THOUGHTS

-- MANIC PHASE

-- ELEVATED, IRRITABLE, OR EXPANSIVE MOOD

-- GRANDIOSITY

-- EXTREME TALKATIVENESS

-- FLIGHT OF IDEAS

-- DISTRACTIBILITY

-- INCREASED GOAL-DIRECTED ACTIVITIES

-- EXCESSES IN PLEASURABLE ACTIVITIES

SCHIZOPHRENIA

ARISING IN ADOLESENCE OR EARLY ADULTHOOD AND INVOLVING A RANGE OF SYMPTOMS RELATED TO

-- DELUSIONAL THOUGHT CONTENT

-- LOOSENING OF THOUGHT ASSOCIATIONS

-- VARIOUS FORMS OF HALLUCINATIONS

-- FLAT OR INAPPROPRIATE AFFECT

-- PERPLEXITY ABOUT ONE'S OWN IDENTITY

-- GROSSLY IMAPIRED ROLE FUNCTIONING

-- DIFFICULTY IN INTERPERSONAL RELATIONSHIPS

-- PSYCHOMOTOR DISTURBANCES FROM CATATONIA TO ODD MANNERISMS