Utah’s Multicultural Disability Network

Community of Practice Meeting – February 18, 2026

“Addressing the Mental Health Needs of Persons with Disabilities” with Dr. Michael Gerald

Q&A Overflow

1. **Would love for you to touch on Anosognosia for practioners! I think alot of folks experience clients with it and have difficulty navigating those conversations, so I'd love to hear your perspective! Thanks!**

This is a really great question and, admittedly, I needed to refresh myself on the definition of Anosognosia in order to answer this. Our approach is *insight-oriented*, so I think it fits well with what this particular question is asking. Here are a couple of thoughts I have, as we have many clients who demonstrated limited insight, however, for some of our clients impaired insight can come from denial, shock, rejection, developmental disability, and, of course, severe and persistent mental illness.

What we have found in our work is that *telling clients* that they are functioning a certain way or experiencing a certain impairment has not been as helpful. I want to be clear, I’m not suggesting the questioner is suggesting we should do that, we have just found that confrontation, psychoeducation, and feedback have not been as helpful because they can, potentially, put the clinician *at odds* with the client. So, what we have found, is that utilizing active listening skills such as *reflections of meaning* and *interpretation* can help us to identify *themes*, *emotional experiences*, and *deeper meaning* that the client may be conveying. We find that this is a more effective way to establish *agreement* between the counselor and the client, which promotes the collaborative commitment, and subsequently fosters a healing therapeutic relationship. For instance, a client of mine may be describing experiences that are indicative of a state of delusion, and I can reflect the *emotional experience* of something like *fear* or *persecution*, which the client is likely to endorse. In this way, clients feel as though we are *in alignment* with them when it comes to their perspective, which can reduce resistance to insight, while promoting *empowerment* because insight would, theoretically, come from the client. Most all of my clients come to their own meaning or conclusions or identification and do not attribute the conclusion to anything related to therapy sessions. It can all feel as though it comes from them.

The one other thing I would offer is to always tie meaning making *to impairment*. Meaning, one of the traps I see clinicians fall into (particularly when serving persons with disabilities) is to assume the presence of problem, based on the presence of disability. In this way, clinicians can assume that the client has an objective problem that needs to be addressed, such as delusions, hallucinations, problematic behavior, etc. What we have found is that many of our clients perceive their problems differently than we do. The problem, as my client sees it, may actually be that *no one seems to understand how great I am* or that chronic pain is distressing because *people do not believe me*. So, for our clients, there are times when we may perceive the problem differently than they do and we have found that the only effective way to *build insight* is to ensure that we are aligned with the problem as *they see it*. Once clients see that I am willing to *accept* their perspective, without challenge, rebuke, or correction, then they are willing to engage in therapy less defensively, more openly, which we have found promotes the development of insight in a way that promotes the maintenance of a positive sense of self.

I want to be clear, though, that I am not an expert on Anosognosia and am merely speaking broadly regarding how we work with clients across the spectrum of disability and level of insight. For clients of ours with specific diagnoses that may manifest more clinical presentations of Anosognosia, such as severe and persistent mental illness or dementia, our approach would be the same.

2. **How do you make people with disabilities feel comfortable about themselves so they can function and be accepted in a world who does not want them.**

This is a difficult question to answer, not because it is poorly worded or challenging in any way, but because the implications of it are painful, yet true. I shared this in another presentation I provided with a colleague recently: "How can we promote a positive disability identity when disability may be the thing we are trying to mitigate, minimize, or correct?" As the questioner has noted, disability, particularly in the medical model, is the thing to be addressed. It is the source of the problem, which, unfortunately, *resides within the individual*. To another part of the question, is it merely that the world was designed for one group and not another, as though by error or oversight. However, the world was not designed for non-disabled persons due to an oversight or error, and instead it was done so *intentionally* because persons with disabilities were not expected to participate in it. The world was designed in this way specifically because *one group of people was <u>valued</u> over another*.

Persons with disabilities, including disabled activists, have long sought to not only achieve civil liberties, social equality, and existence with dignity, but have also had to simultaneously *prove that their lives are worth living*. This is not unique among marginalized persons, per se, but the history of devaluing persons with disabilities is due to the perception that our lives are not worth living, are tragic in some way, and constitute a lesser or inferior existence. Persons with disabilities have long been perceived as burdens and our social programs, such that they exist, seek to either return them to work or keep them in a perpetual state of social and economic poverty. This is all because persons with disabilities are not, and never have been, viewed as *equal persons*. Instead, people with disabilities are viewed with pity, sympathy, fear, derision, resentment, because our lives are perceived as *less than*.

Okay, so now to answer the question. If that answer is too much of a 'hot take,' please feel free to leave it off of the materials.

When it comes to assisting someone in developing an affirmed sense of self, particularly when aspects of one's identity are socially maligned or stigmatized, the key is to *demonstrate* the following conditions: **unconditional positive regard**, **nonjudgmental acceptance**, **deep empathic understanding**, and **genuineness and authenticity**. These conditions not only need to be demonstrated by us, but they need to be *received* by the other person. Further, and this is where I recognize some might disagree with our approach, our nonjudgmental acceptance and unconditional regard must demonstrate that a person, as they are, is acceptable *without* correction. This can be difficult with persons with disabilities as the very thing that is causing distress (disability) can also simultaneously be a major source of identity. So, what we want to offer is *understanding of experience*, without correction, guidance, or modification. Again, I recognize this can be difficult, as we often want to help persons with disabilities by solving problems, reducing symptoms, improving functioning, or connecting them with resources. Although these practices are *sometimes* helpful with persons with disabilities, I would posit that they also demonstrate to persons with disabilities that they are *incapable* of doing these things on their own.

Instead, I wish to demonstrate to clients of mine that I trust their judgment, regardless of specific choices, and that I trust their ability to seek out services that may be helpful to them or to engage in activities they may find beneficial. This unconditional trust and regard in my clients, coupled with acceptance of them while building insight, can help preserve a sense of self that is not maligned or pathologized. What I do not want is for my clients to experience themselves as having a part of themselves that is *unacceptable*. I avoid and refrain from praise, setting goals or expectations, or simple affirmations with my clients, because I do not want them to feel as though they are being evaluated by me or that there is something they need to do to receive my care and regard. Instead, I might offer to my clients that I care about them and *wish* I could help them solve their problems (this is not a manipulation, as most of the time I have no idea what they should do in a given situation).

The demonstration of unconditional regard and acceptance demonstrates to another person that *who they are* is acceptable *exactly as they are*, while providing the foundational relationship necessary for growth, *without* any sort of parameters regarding what that growth should look like or end up as. My wish for persons I serve is that they grow and develop into whoever they will become, not for them to grow into a version of themselves that my treatment manual wants or that I think would be most effective for them.

### 3. How we can talk with families about MH needs of those with IDD?

This is an excellent question and I am grateful to the person who asked it. The first thing I do with families, caregivers, and other service providers is to provide psychoeducation regarding the mental health needs of persons with IDD. Persons with IDD have higher rates of mental health distress relative to the general population, but lower rates of service utilization. There are a few reasons for this, but chief among them are barriers to services, such as lack of specialized services, lack of specialized providers (or willing providers), and ineffective service collaboration among agencies. Sadly, research with mental health providers themselves demonstrates that many practitioners do not feel they have the training required to meet the mental health needs of persons with IDD. The question becomes: what are the mental health needs of persons with IDD? In my experience, persons with IDD demonstrate and manifest symptoms of any number of DSM disorders, but these are often overlooked do to the concept of *diagnostic overshadowing*. “Diagnostic overshadowing” occurs when mental health practitioners and other professionals attribute mental health symptoms to a person’s intellectual disability, rather than considering them to be evidence of a comorbid mental health disorder. Although there is a DM-ID, which is adapted from the DSM to provide diagnostic criteria of mental disorders for persons with IDD, many practitioners are not aware of it.

So when it comes to talking to families, the first thing I try to describe is the *very real presence* of psychological distress that is the same as persons without IDD, but it may manifest differently. For instance, clients of mine with IDD do still experience feeling left out, excluded, hopeless, purposeless, anxious, sad, suicidal, etc., but it may manifest as playing video games for hours, which families may believe requires a behavioral intervention or some kind of skill development. Because persons with IDD are often viewed as lacking insight, and even the capacity for insight, and as manifesting skill deficits, they are often subjected to behavioral interventions designed to improve functioning, reduce behavior excesses, and improve behavior deficits. Although these are noble endeavors to be sure, they can impel providers to overlook underlying psychological distress or meaning making that is driving distress. A client of mine with ASD and IDD has described wishing they were “normal,” and not a person with a disability, due to the impact it has had on social connections with others. By approaching clients with IDD in the same manner I approach other clients and advocating for their needs by providing education to family members on their state of mind and the potential sources of their behaviors and emotions, I am attempting to provide an environment where the emotional and psychological needs of my client are prioritized, rather than simply focusing on their behaviors.