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MRCPsych Intellectual Disability Module

History Taking and Communication in Patients with an Intellectual Disability

Developing people for health and healthcare

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Aims and Objectives (from handbook)

- The overall aim is for the trainee to gain an overview of history taking in ID

- By the end of the sessions, trainee should have:
  - Awareness of the difficulties encountered in assessing patients with an intellectual disability
  - Be able to use of other forms of communication rather than just verbal
  - Understand the importance and role of the developmental history
  - To have developed an understanding of how patients with an intellectual disability can present with conditions such as a mental disorder

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To achieve this

- Case Presentation
- Journal Club
- 555 Presentation
- Expert-Led Session
- MCQs

- Please sign the register and complete the feedback

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ID Module: History Taking and Communication in Patients with an Intellectual Disability

Expert Led Session

Assessment, Interviewing & Gathering Information in Adults with Intellectual Disability

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Hints for Psychiatric Interviewing

Rules of good interviewing similar to those applicable in the general population.

1- People with intellectual disabilities more likely to say what they believe the interviewer wants to hear.

2- They have a short attention span. Therefore recap and summarise.

- ***Information from Informants:***

  Relatives, people with whom the patient lives, care staff, other professionals involved gather as much information as you can.

When Interviewing

- ***Put the person at ease***. Remove fears. Reassure and stress confidentiality. Try an engage by talking about familiar things.
- ***Minimise the reasons for Yes answers*** Ask contradictory questions.
- ***Establish an "anchor" event to help patients time focus.*** An event which fixes a period of around 4 weeks prior to the interview.

When Interviewing:

- ***Keep the language as simple as possible.***
  - Check whether they understand.
  - Use the simplest possible question form.
  - What? When? Which? Who? Why?.
  - Leading questions are not useful.
  - Try to use open questions.
  - Use positive question forms.

When Interviewing:

- ***Probe each symptom thoroughly.***
  - A "***yes***" response to a probe is not sufficient to rate a symptom as present. Attempt to obtain a description of the symptom.
  - Repeat questions.
- ***Assessment of communication ability is necessary at the outset.***
  - There may be discrepancy between verbal and non-verbal performance. Many people with intellectual disability are highly skilled at covering up their poor understanding and avoid being seen as incompetent.

History:

- **Referral:**
  - Why and by whom.
- **Presenting complaints:**
- **History of presenting complaints:**

  Precipitating factors.

  Recent life events and changes.

  Symptoms: affective; cognitive and physical.

  Behaviour problems (ABS part II or ABC).

  Changes in skills and social functioning.

History:

- **Past psychiatric history:**
- **Past medical history:**
- **Physical history:**
  - Vision, hearing and dental care and any mobility difficulties.
- **Medication history:**
  - Prescribed drugs.
  - Over-the-counter drugs.
  - Compliance, administration and effectiveness.
  - Side effects (Ask about common side effects, EPSE, TD)
  - **Substance and alcohol use**

History:

- **Forensic history:**
- **Family history:**

  FH of : developmental disorders, physical & mental illness, epilepsy.
- **Developmental history:**

  Pregnancy.
  Birth history.
  Neonatal history.
  Early milestones.
  Social development

History:

- **Education:**
  Nursery.
  Primary schooling.
  Secondary schooling.
- **Personal & social history:**
  School leaving & transition.
  Further education.
  Employment history.
  Home circumstances.
  Past & recent life events.

History:

- **Skills:**
  - Communication.
  - Activities of daily living.
- **Personality:**
  - Likes and dislikes.
  - Interests.
  - Relationships.
  - Coping styles; reactions to stresses and illness.
- **Services and benefits**

Mental State Examination

- Many diagnostic processes rely on patients description of complicated internal phenomena, people with severe or profound intellectual disabilities will not be able to do this.
- Reliant on patient observation. Ask carers about any changes in behaviour, any new symptoms.
- Sleep, weight , level of activity.
- Use visual aids as pictures drawings.

Appearance & behaviour

- ***Motor activity*:**

  Restlessness, fidgetiness.

  Spasticity, gait,. Co-ordination problems.

  Involuntary movements.

  Tics. Stereotopies. Mannerisms. Posturing. Rituals.

- ***Social response at interview*:**

  Social use of language & gesture

  Rapport: odd, aloof.

  Eye contact

  Reciprocity: e.g. Turn taking.

  Empathy

  Social style: e.g. reserved, expansive, disinhibited, over friendly, cheeky,

Speech & Language:

- Hearing: sounds and speech.
- Comprehension
- Speech / vocalization
- (a) spontaneity
- (b) quantity e.g. mute, poverty of speech and content.
- (c) rate and flow
- (d) Stuttering
- (e) Complexity of sentences
- (f) Echoing
- (g) use of gestures

Affect:

- Emotional expressiveness and range
- Anxiety symptoms (General, specific)
- Sadness, tearfulness
- Irritability, anger, labile

Thought contents:

- Worries, fears.
- Preoccupations.
- Hopelessness, guilt.
- Low self esteem.
- Depressive thoughts
- Suicidal thoughts (or behavioural equivalents)
- Homicidal thoughts
- Fantasies, wishes.
- Thought alienation: thought reading, broadcasting.

- **Obsessions & compulsions:**
- **Abnormal beliefs:**

  Overvalued ideas, delusions.

  Ideas / delusions of reference.

  Delusions of control, persecution etc
- **Abnormal experiences:**

  Auditory, visual, somatic or other sensory hallucinations.

  Imagery and pseudo hallucinations
- **Cognition / intelligence:**

  Level of consciousness / alertness

  Test as for normal adults

  Consider tests for frontal / temporal lobe functioning

  Current IQ: Wechsler Adult Intelligence Scale (WAIS)

- **Insight:**

  How does the person perceive and understand their mental and physical health?

- **Valid consent:**

  understands she/he can make a choice;

  is able to exercise that choice;

  can understand risks and benefits of proposed investigation or treatment.

  What helps the person to take in information (e.g. pictures, cartoons, repeated explanations, visits to EEG / CT scan dept)

Physical and Neurological Examination:

- Look for associated dysmorphic features.
- Look for common physical disorders
- Look for conditions associated with particular syndromes

Diagnostic Scales

- Specific semi-structured interviews may be used (e.g. Psychiatric Assessment Scale for Adults with Developmental Disabilities).

- Various questionnaires and semi structured interviews may be used in the diagnosis of autistic spectrum disorders, attention deficit disorders or assessment of behavioural problems.

Formulation / Summary

- Descriptive formulation
- ICD-10 diagnosis: Use the multi-axial classification system as per DC-LD
- Aetiology: Physical / Social / Psychological
- Investigations:

  (a) to confirm and describe the person's LD

  (b) confirm any other developmental disorder's (c) Physical / Social / Psychological investigations
- Interventions: Physical / Social / Psychological
- Legal & ethical issues (e.g. consent, Mental Health Act)

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Any Questions?

Thank you…. MCQs are next...

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MCQs

1. With regard to people with intellectual disabilities, which of the following is false:

A. Diagnosis of intellectual disability is dependent on significantly sub-average IQ and associated deficits in adaptive behaviour with onset occurring before 18 years of age

B. The prevalence of intellectual disability in the general population is 3%

C. Mental health problems are more common than in the general population

D. Mental health problems always present as challenging behaviour

E. The philosophy of normalisation supports people with intellectual disabilities accessing generic health services.

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MCQs

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MCQs

2. According to ICD-10, the following is not a degree of mental retardation:

A. Borderline
B. Moderate
C. Profound
D. Severe
E. Mild

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MCQs

2. According to ICD-10, the following is not a degree of mental retardation:

A. Borderline

B. Moderate

C. Profound

D. Severe

E. Mild

.

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MCQs

3. Disruptive and dissocial behaviour occurs more commonly in which of the following category?

A. Mild intellectual disability

B. Moderate intellectual disability

C. Severe intellectual disability

D. Profound intellectual disability

E. Equally common across all categories

.

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MCQs

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E. Equally common across all categories

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MCQs

4. The prevalence of epilepsy in the intellectual disability population is approximately:

A. 1-2%

B. 5-10%

C. 10-15%

D. 20-25%

E. 50%

.

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MCQs

4. The prevalence of epilepsy in the intellectual disability population is approximately:

A. 1-2%

B. 5-10%

C. 10-15%

D. 20-25%

E. 50%

.

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MCQs

5. The communication style that does not interfere with assessment in the intellectual disability population is:

A. Denial
B. Fabrication
C. Engagement
D. Digression
E. Suggestibility

.

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MCQs

5. The communication style that does not interfere with assessment in the intellectual disability population is:

A. Denial

B. Fabrication

C. Engagement

D. Digression

E. Suggestibility

.

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Any Questions?

Thank you.