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# MRCPsych Intellectual Disability Module

## Mental Disorders in Intellectual Disability

*Acknowledgment*
*Dr P Patel*

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# Mental Disorders in Intellectual Disability

## Aims and Objectives (from handbook)

- **Aims**
- Recognising and identifying how the presentation of mental disorders differs in ID population
- Importance of collateral information from various sources
- Role of medication/ doses/side effects

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# Mental Disorders in Intellectual Disability

## 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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# Mental disorders in the ID population

Dr Pradip Patel
Consultant Psychiatrist
Lancashire Care NHS Foundation Trust
Pradip.Patel@lancashirecare.nhs.uk

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# AIMS AND OBJECTIVES

- Provide an overview of mental health problems in people with intellectual disability

- Give a brief overview of common psychiatric disorders, their prevalence, diagnostic difficulties and discuss differences in clinical presentation as compared to the general population

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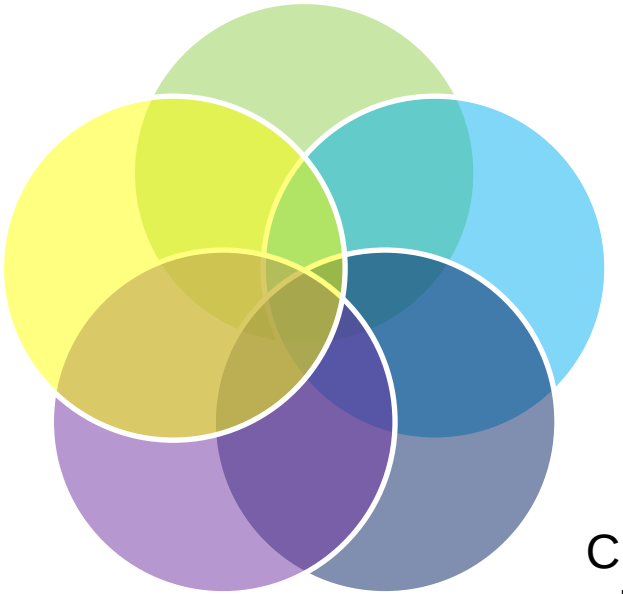
# COMPLEX INTERACTIONS BETWEEN ID, PHYSICAL HEALTH AND MENTAL DISORDERS

INTELLECTUAL DISABILITY

AUTISTIC SPECTRUM DISORDERS



MENTAL ILLNESS

PHYSICAL HEALTH

CHALLENGING BEHAVIOUR

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# Prevalence of mental illness in adults with intellectual disability

- Studies on prevalence of **psychiatric illness** among **adults** with intellectual disability report a wide range, between 10% - 39%
- Prevalence depends on the sample selection; definition of psychiatric illness (some included and some excluded diagnoses such as behavioural disorders, pervasive developmental disorders and dementia); the diagnostic criteria used; and the diagnostic methods used.

. Borthwick-Duffy SA. Epidemiology and prevalence of psychopathology in people with mental retardation. *Journal of Consulting & Clinical Psychology* 1994; **62(1)**: 17-27

Elita Smiley ***(2005),*** **Epidemiology of mental health problems in adults with learning disability: an update** ***Advances in Psychiatric Treatment vol. 11, 214–222***

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# Psychiatric illness and severity of Learning (Intellectual) Disability

- It is not clear whether or not the prevalence of psychiatric illness increases with the severity of intellectual disability[i,ii,iii].


i. Corbett J. Psychiatric morbidity and mental retardation. In *Psychiatric Illness and Mental Handicap.* (eds. FE James and RP Snaith). London: Royal College of Psychiatrists, Gaskell Press, 1979. pp.11-25

ii. Göstason R. Psychiatric illness among the mentally retarded. A Swedish population study. *Acta Psychiatrica Scandinavica, Supplementum* 1985; **318**:1-117

iii. Lund J. The prevalence of psychiatric morbidity in mentally retarded adults. *Acta Psychiatrica Scandinavica* 1985; **72(6)**: 563-70

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# Prevalence of specific mental illness

Prevalence of specific psychiatric illnesses in adults with intellectual disability [i,ii,iii,iv].

- The point prevalence of **schizophrenia** is reported as between 1.3% and 3.7%.
- The point prevalence of **affective disorders** including **depressive illness** and **mania** are reported as between 1.2% and 6%.
- The point prevalence **of anxiety related neurotic disorders** is found in around 16.4% adults (20-64 years).


i. Turner TH. Schizophrenia and mental handicap: an historical review, with implications for further research. *Psychological Medicine* 1989; **19(2)**: 301-14

ii. Lund J. The prevalence of psychiatric morbidity in mentally retarded adults. *Acta Psychiatrica Scandinavica* 1985; 72(6): 563-70

iii. Hagnell O, Öjesjö L, Otterbeck L, Rorsman B. Prevalence of mental disorders, personality traits and mental complaints in the Lundby study. *Scandinavian Journal of Social Medicine. Supplementum.* 1993; **21(Suppl.50)**: 1-76

iv. Cooper SA. Psychiatry of elderly compared to younger adults with intellectual disability. *Journal of Applied Research in Intellectual Disability* 1997; **10(4)**: 303-11

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# Estimated prevalence rates for mental disorder from population-based studies of adults with LD

- Schizophrenia 3%
- Bipolar affective disorder 1.5%
- Depression 4%
- Generalised anxiety disorder 6%
  - Specific phobia 6%
  - Agoraphobia 1.5%
- Obsessive–compulsive disorder 2.5%
- Dementia at age 65 years and over 20%
- Autism 7%
- Severe problem behaviour 10–15%

Elita Smiley ***(2005),*** **Epidemiology of mental health problems in adults with learning disability: an update** ***Advances in Psychiatric Treatment vol. 11, 214–222***

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# Anxiety Disorders in people with intellectual disability

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# ANXIETY DISORDERS AND intellectual disability

- Subjective criteria needed for diagnosis of anxiety disorders difficult to apply in those who are nonverbal and those with communication and cognitive deficits e.g. fear of ‘going crazy’ or losing control, or feeling of apprehension and anxious foreboding
- More reliance needs to be given to observable signs e.g. looking fearful, sweating, trembling, hyperventilation or clutching or rubbing chest or choking and avoidance of specific situations, heightened startle response, decreased concentration, insomnia

# Classification of Anxiety Disorders

- Panic disorder
- Agoraphobia
- Social phobia
- Specific phobia
- Generalised Anxiety Disorder (GAD)
- Obsessive Compulsive Disorder (OCD)
- Acute and post-traumatic stress disorders

# Prevalence in those with ID

- Well recognised (Bailey & Andrews)
- Under-reported (Reiss 1982)
- Under-diagnosed (Veerhoven 1997)
- Higher rates in older vs younger (Cooper 1997)
- Higher rates of phobias in LD (Deb 2001)

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# ANXIETY DISORDERS

- Anxiety may be manifested as behaviour problem when the person can't communicate their worries verbally – Matson et al. 1997
- Agitation, screaming, withdrawal, regressed/clinging behaviour, freezing, crying may indicate fear – Khreim & Mikkleson 1997

Matson, J., Smiroldo, B., et al. (1997). Do anxiety disorders exist in persons with severe and profound retardation? *Research in Developmental Disabilities,* 18, 39-44.

Khreim, I. & Mikkleson, E. (1997). Anxiety disorders in adults with mental retardation. *Psychiatric Annals,* 27, 271-281.

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# SYNDROMES ASSOCIATED WITH ANXIETY DISORDERS

- Fragile X
  - Social anxiety disorder
- Rubinstein-Taybi & Prader-Willi
  - OCD (Levitas & Reid 1998)
- Williams
  - Anxiety and phobias (Einfeldt, Tonge & Rees 2001)
- Cornelia de Lange
  - Compulsive behaviours (Hyman, Oliver & Hall 2002)

Levitas, A., & Reid, C. (1998). Rubinstein-Taybi syndrome and psychiatric disorders. *Journal of Intellectual Disability Research,* 42(4), 284-292

Einfeldt, S., Tonge, B., & Rees, V. (2001). Longitudinal course of behavioural and emotional problems in Williams syndrome. American Journal on Mental retardation, 106, 173-181.

Hyman, P., Oliver, C.,Hall, S. (2002). Self injurious behaviour, self restraint and compulsive behaviour in Cornelia de Lange syndrome, *American Journal on Mental Retardation,* 107(2), 146-154.

# OCD AND intellectual disability

- The diagnostic requirement that the individual recognises his/her compulsions as excessive or unreasonable cannot be established in most with LD
- Simple repetitive behaviours as opposed to compulsive behaviours that appear driven or an insistence on sameness can be seen in PDD (Autism Spectrum)
- Widely variable prevalence of compulsive behaviours reported in LD (3.5% to 40%), Vitiello et al, 1989); Bodfish et al, 1995)

# OCD AND intellectual disability

- Compulsive behaviour is well documented in Prader Willi syndrome, Down Syndrome,  Fragile X and Williams syndrome
- Ordering compulsions more frequent
- It is more difficult to establish presence of obsessions in an individual with LD . They may be unable to recognise it as coming from their own mind and resistance may not occur.

Vitiello , B., Spreat, S., & Behar, D. (1989). Obsessive-compulsive disorder in mentally retarded patients. *Journal of Nervous and Mental Disease, 177,* 232-236
Bodfish, J., & Madison, J. (1993) Diagnosis and fluoxetine treatment of compulsive behaviour disorder of adults with mental retardation*, American Journal on Mental Retardation,* 98, 360-367.

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# Depression in people with intellectual disability

# Review paper Depression and LD McBrien (JIDR 2003)

- Debate until 1980's about whether people with LD (ID) can suffer from depression
- Cooper 1996 – depression may be missed if standard criteria used, different presentation in LD, no suitable rating scale
- Difficulty in ascertaining exact prevalence due to problems in case identification
- Many studies modify ICD/ DSM criteria; adding behavioural changes to criteria helps

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# Clinical presentation

- Smiley (JIDR 2003) – literature review for DC-LD
  - **Common symptoms** : depressed, irritable, labile mood; onset or increase in aggression; onset or increase in problem behaviours ( SIB, screaming); tearfulness, loss of skills, reduction in speech, withdrawal, somatic complaints, anhedonia, lethargy, sleep &/or appetite changes, onset or increase in agitation/ retardation
  - **Uncommon symptoms**: ideas of worthlessness, guilt, low self esteem, morbid suicidal thoughts

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# DC-LD CATEGORY IIIB4.1- DEPRESSIVE EPISODE

- A: Symptom present nearly everyday for at least 2 weeks
- B: Not due to drugs or other physical disorders e.g. hypothyroidism
- C: criteria for mixed affective episode or schizo-affective episode not met
- D: Symptoms represent a change from premorbid state
- E: Item 1 or 2 must be present and prominent:
  1. Depressed mood (misery, low mood throughout day) OR irritable mood (onset or increased aggression, reduced tolerance)
  2. loss of interest or pleasure in activities or social withdrawal or reduction in self care or reduction in quantity of speech/ communication

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# DC-LD DIAGNOSTIC CRITERIA FOR DEPRESSION - 2

- F: **Some of following must be present so that at least 4 symptoms from E & F present**
  1. Loss of energy; increased lethargy
  2. Loss of confidence or increase in reassurance seeking behaviour; onset of or increase in anxiety or fearfulness
  3. Increased tearfulness
  4. Onset of or increase in somatic complaints
  5. Reduced ability to concentrate/ distractibility or increased indecisiveness
  6. Increase in specific problem behaviour e.g. aggression or tantrums
  7. Increased motor agitation or motor retardation
  8. Onset of or increase in appetite disturbance or significant weight change
  9. Onset of or increase in sleep disturbance

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# BIPOLAR AFFECTIVE DISORDER AND INTELLECTUAL DISABILITY

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# BIPOLAR DISORDER AND INTELLECTUAL DISABILITY

- Deb & Hunter (1991) reported cyclical changes in behaviour and mood in 4% adults with LD with and without epilepsy
- Cyclical changes in mood and behaviour can be observed even in those with very severe LD
- Observed items include ‘ restless or agitated, decreased sleep, irritable, easily distracted, extremely happy or cheerful for no apparent reason, talks loudly and quickly.
- Mixed affective states and rapid cycling forms may be more common in those with LD (Berney and Jones 1988)
- Mania may be less common in women with Down’s syndrome

Deb , S. & Hunter, D. (1991) Psychopathology of people with mental handicap and epilepsy II: Psychiatric illness. *British Journal of Psychiatry*, 159, 826-830

Berney, T. & Jones, P. (1988) Manic-depressive disorder in mental handicap, *Australia and New Zealand Journal of Developmental Disabilities,* 14, 219-225.

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# Psychosis in people with intellectual disabilities

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# Diagnostic Issues

- ‘Diagnostic overshadowing’
- Schizophrenia may be over diagnosed or ‘misdiagnosed’ in those with LD, especially those in severe/ profound range.
  - Schizophrenia cannot be diagnosed in those with IQ <45 (Reid, AH (1994)
- LD may be ‘masked’ or under diagnosed in those with severe mental illness

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# Misdiagnosis of hallucinations and delusions- a neuro-developmental perspective

- Reported hallucinations and delusions may be:
  - True phenomena but not necessarily due to schizophrenia or psychotic disorder
  - May be self-talk, imaginary friends or fantasy similar to coping mechanisms found in young children
  - Baseline exaggeration
    - Disruptive, aggressive behaviour may have been present for many years and worsened by mental illness
  - Cognitive disintegration
    - Stress or mental illness can lead to breakdown of coping systems and transient loss of abilities and reality testing

Hurley, A.D. (1996) The misdiagnosis of hallucinations and delusions in persons with mental retardation: A neurodevelopmental perspective. Seminars in clinical neuropsychiatry; **1 no 2**, 122-133

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# DEMENTIA AND intellectual disability

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# OVERVIEW OF DEMENTIA AND ID

- Overall prevalence of dementia in people with LD over age 65 is 12% - thus comparable to the general population
- Loss of memory is more difficult to detect. Behaviour problems are more prominent with nocturnal confusion, transient psychotic episodes and late onset epilepsy
- Medical risk factors include hypertension, ischaemic episodes, organic brain damage, associated neurological conditions and family history of dementia

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# DOWNS SYNDROME AND DEMENTIA

- At least 36% of people with Down's syndrome aged 50 – 59 years and 54.5% aged 60 - 69 are affected by dementia (compared to 5% of general population aged over 65 years). The prevalence increases significantly with age.
- The average age of onset is 54 years and the average interval from diagnosis to death is less than 5 years.
- Senile plaques and neurofibrillary tangles almost always present in brains of people with Down's syndrome over age 35 but clinical features only evident later on in life
- The average life expectancy of people with Down's syndrome continues to increase (now over 50 years).

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# SPECIFIC ASSESSMENT TOOLS

- Psychiatric Assessment Schedule for Adults with Developmental Disabilities (PAS-ADD)
  - Comes in different formats: semi-structured interview for professional staff to assess current mental state, and a checklist version for carers as a screening tool (Moss,2002)
- Assessment of Dual Diagnosis (ADD)
  - Provides information on diagnosis, developing treatment plans and evaluating outcomes (Matson & Bamburg, 1998)
- Reiss Screen for Maladaptive Behaviour (adolescents and adults)
  - 38 item scale completed by carers. Applicable to all levels of intellectual disability (Reiss, 1997)

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# SPECIFIC ASSESSMENT TOOLS

- Health of the Nation Outcome Scale for people with Learning Disabilities (HONOS-LD)
  - Useful way of assessing global changes in people undergoing treatment (Roy et al, 2002)
- Camberwell Assessment of Need for Adults with Developmental and/or Intellectual Disability (CANDID – Adults)
  - Semi-structured interview to assess need in people with LD (Xenitidis et a, 2003)
- Diagnostic Assessment of the Severely Handicapped (DASH)
  - 96-item informant rating scale, based on DSM-IV-TR criteria, for use in adults with severe to profound LD (Matson, Coe, Gardner & Sovner, 1991).

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# CONCLUSION

1. Mental disorders are common in people with learning (intellectual) disabilities

2. Psychiatric assessment should include all aspects of the standard psychiatric assessment as used with the general population *plus* additional considerations relevant specifically to people with intellectual disabilities

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# CONCLUSION

3. Classification of mental disorders requires an appropriate system with valid diagnostic criteria: DC-LD has been specifically formulated for people with learning [intellectual] disabilities, and can be used to complement ICD-10.

4. Aetiology of mental disorders is best understood using a ***biological-psychological-social-developmental framework***. The same framework is also useful when designing plans of treatment/intervention/support

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# Mental Disorders in Intellectual Disability

## MCQs

1. In individuals with severe intellectual disability, self-injurious behaviour has a peak occurrence between the ages of:

   A. 10 – 15 years
   B. 15 – 20 years
   C. 20 – 25 years
   D. 25 – 30 years
   E. 35 – 40 years

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# Mental Disorders in Intellectual Disability

## MCQs

1. In individuals with severe intellectual disability, self-injurious behaviour has a peak occurrence between the ages of:

A. 10 – 15 years
**B. 15 – 20 years**
C. 20 – 25 years
D. 25 – 30 years
E. 35 – 40 years

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# Mental Disorders in Intellectual Disability

## MCQs

2. Self-Injurious behaviour is common in which of the following:

   A. Cri du chat syndrome
   B. Angelman syndrome
   C. Down syndrome
   D. Cornelia de Lange syndrome
   E. Lesch Nyhan syndrome

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# Mental Disorders in Intellectual Disability

## MCQs

2. Self-Injurious behaviour is common in which of the following:

A. Cri du chat syndrome
B. Angelman syndrome
C. Down syndrome
D. Cornelia de Lange syndrome
**E. Lesch Nyhan syndrome**

# Mental Disorders in Intellectual Disability

## MCQs

3. Prevalence of depression in ID is around:

A. 1%
B. 2 – 4%
C. 5 – 15%
D. 16 – 25%
E. 26 – 35%

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# Mental Disorders in Intellectual Disability

## MCQs

3. Prevalence of depression in ID is around:

A. 1%
**B. 2 – 4%**
C. 5 – 15%
D. 16 – 25%
E. 26 – 35%

# Mental Disorders in Intellectual Disability

## MCQs

4. Which of the following apply to the PAS-ADD:

   A. Was developed from the SCID
   B. Focuses exclusively on Axis II disorders
   C. Designed for completion by carers with knowledge of psychopathology
   D. Each item is rated on a 6 point scale
   E. It comprises a life events and problems section

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# Mental Disorders in Intellectual Disability

## MCQs

4. Which of the following apply to the PAS-ADD:

   A. Was developed from the SCID
   B. Focuses exclusively on Axis II disorders
   C. Designed for completion by carers with knowledge of psychopathology
   D. Each item is rated on a 6 point scale
   **E. It comprises a life events and problems section**

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# Mental Disorders in Intellectual Disability

## MCQs

5. In patients with ID and schizophrenia, compared with patients with ID alone, the following were noted:

A. Impaired mobility
B. High birth weight
C. Gestation beyond 38 weeks
D. Impaired hearing
E. Low rates of obstetric complications

# Mental Disorders in Intellectual Disability

## MCQs

5. In patients with ID and schizophrenia, compared with patients with ID alone, the following was noted:

   A. Impaired mobility
   B. High birth weight
   C. Gestation beyond 38 weeks
   **D. Impaired hearing**
   E. Low rates of obstetric complications

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# Mental Disorders in Intellectual Disability

Any Questions?

Thank you.