

APPROACH TO SIMPLE MENTAL HEALTH CONDITIONS IN PERSONS WITH INTELLECTUAL DISABILITY

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ABSTRACT

Persons with Intellectual Disability (ID) have a higher incidence of mental health disorders compared to the general population. This article aims to provide practical approaches as well as clinical pointers to the assessment and treatment of common psychiatric conditions such as depression and anxiety disorders in persons with ID. It is hoped that these can help inform and be adopted into family practice settings, to increase accessibility and improve on the care available to this special population.

Keywords: Psychiatry, Mental Health, Intellectual Disability, Depression, Anxiety Disorders

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INTRODUCTION

Persons with Intellectual Disability (ID) are at increased risk of developing mental health conditions due to the presence of often multiple biological, psychological, social, and family factors. Prevalence rates of psychiatric disorders in persons with ID have been found to be as high as 40 percent.¹ They suffer from the same types of disorders as people without disability, but the causes and presentations may be shaped by the increased vulnerability factors as well as developmental level of the individual. People with mild intellectual disability display similar signs and symptoms to the general population, but those with greater disability may exhibit changes that are likely more behavioural in nature. We will also need to rely more on information from caregivers on top of direct report of symptoms from the patient, which may be scarce. Care has to be taken to avoid “diagnostic overshadowing”, when signs of a psychiatric disorder are inappropriately attributed to the person’s disability rather than from mental health needs.

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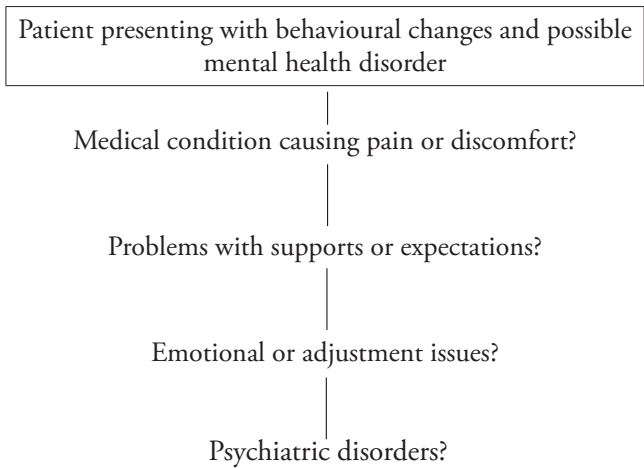
INITIAL APPROACH IN THE ASSESSMENT PROCESS

As a person with ID will most probably first present to the doctor with behavioural issues, it is helpful in the initial approach to tease out other likely contributing factors to behaviour changes, before the assessing doctor assesses the symptoms that could signal the presence of a psychiatric disorder (refer to **Figure 1**).

First, medical conditions that can cause pain or discomfort can result in disordered behaviour, especially in the more severely disabled who have difficulties communicating verbally.² Common physical health issues will be covered in Unit 3, but it is necessary to highlight here that even simple medical conditions such as constipation and gastro-oesophageal reflux may result in much distress and behavioural changes.

Second, the level (or lack) of support that is given to the person with ID can often influence the behaviour. Persons with ID with verbal communication difficulties may need communication aids such as using a Pictorial Exchange System (PECS) or sign language. If these are not available in his/her current environment, this may result in maladaptive ways to communicate needs. Associated visual or auditory impairment may worsen the situation, and likewise physical disabilities such as cerebral palsy. Some may also have sensory needs, e.g., sensory modulation difficulties, especially seen in those with autism. This can be in the form of being hypersensitive to lights, sounds, or touch, which often leads to behavioural problems when they feel overwhelmed, especially when they are placed in a new environment such as a new School or Day Activity Centre. On the other hand, sometimes the behavioural issue may arise not because of inadequate supports but rather due to the lack of understanding or mismatched expectations on the part of the caregivers, and it may be helpful to discuss and moderate these expectations with them.

Next, it is helpful to look into possible emotional precipitants to the change in behaviour. It is normal for persons with ID to experience psychological or emotional distress after going through certain changes in their lives, such as a change in residential setting or the teachers/trainers or people caring for them, and certain behavioural responses can be seen as understandable, even adaptive. Because of their disability, there may be greater challenges in making sense of and coping with transitions, but they can often be helped through preparing and counselling them through these changes, e.g., through the use of social stories or teaching coping skills. It is when the distress is persistent and leads to much functional impairment that we begin to look into the presence of possible psychiatric disorders.



COMMON PSYCHIATRIC CONDITIONS SEEN IN PWIDs

The most commonly seen conditions that could develop in persons with ID are depression and anxiety disorders.

Depression

Five of the nine symptoms listed in DSM-5³ have to be present for at least two weeks to make the diagnosis of a major depressive disorder. Any of these symptoms can be observed regardless of language capabilities or level of intellectual disability, but the depression in persons with ID tends to be more insidious and changes seen may be less dramatic.⁵ The symptoms include:

- Evidence of a depressed mood. In persons with ID, these may not be expressed directly, but may manifest as tearfulness, increased irritability, or an increase in somatic complaints. Oftentimes, we may need to rely on the description by caregivers of a change in the individual from usually being smiling, laughing, or having a sense of humour to an absence of such expressions.
- Diminished interest or pleasure in activities. This may be shown by no longer interacting much with others, refusing to participate in activities or outings, or just appearing apathetic about things that used to interest them in the past.
- Appetite and weight changes. This may be expressed as a refusal to go for meals or a refusal to eat even when presented with their favourite foods. Serial recording of weight over time is important, as it may be the only objective evidence of this symptom.
- Insomnia or hypersomnia. Sometimes there may be behavioural disturbances that occur at bedtime, and this may distract from the fact that the person has problems falling asleep. It is helpful to ask caregivers about the sleep patterns, to understand if the person is sleeping through the night, sleeps late, awakens early, or is sleeping longer than usual.

- Psychomotor agitation or retardation. Agitation may present as restlessness, inability to sit still, just pacing around, or even aggression. In fact, persons with ID and depression are more likely to demonstrate aggressive behaviour than persons without ID who are depressed.⁶ Conversely, retardation may be seen as the person taking a long time to do things, or just eating and walking very slowly.
- Fatigue or loss of energy. Besides a preference to stay in bed or refusing to do activities, this may also manifest as a deterioration of social and self-care skills.⁷
- Feelings of worthlessness or excessive or inappropriate guilt. These may sometimes be expressed through statements like “I cannot do anything”, “nobody likes me”, or by behaviour such as throwing out things or destroying them without any apparent reason.
- Diminished ability to think or concentrate may be expressed as decreased productivity or the regression of skills. Often the person may start a task but not follow it through. Caregivers may also report that the person is unable to make decisions or constantly changes his/her mind.
- Recurrent thoughts of death, recurrent suicidal ideation, or a suicide attempt. Sometimes this can be expressed through repeated self-injurious behaviour or offering oneself up to peers who are known to be aggressive.

ANXIETY DISORDERS

Anxiety is a frequent symptom in people both with and without ID, and as discussed earlier, does not amount to a disorder unless it results in significant and persistent functional impairment. Common conditions classified under this group of disorders include generalised anxiety disorder (GAD), panic disorder, post-traumatic stress disorder, social anxiety disorder and specific phobias. Obsessive-compulsive disorder (OCD) used to be conceptualised as a form of anxiety disorder as well, and was categorised under this group until the development of DSM-5, when it was placed in its own category. We can similarly employ the same diagnostic criteria for each of the anxiety disorders in our assessment as we do for those without intellectual disability, though it is recognised that it might be challenging to get a history of subjective symptoms of anxiety if there are verbal communication difficulties.

For such persons, it is helpful to recognise if they have persistent physical signs of anxiety. These may include an excessively upright rigid posture, tense jaw muscles, teeth-grinding, excessive perspiration, fast breathing, chewing of fingernails, exacerbation of tics, or some form of self-abusive behaviour. Similarly in OCD, it might be challenging to diagnose obsessions because of the difficulty persons with ID have in describing their thoughts. However, compulsions can be observable, including the mounting anxiety or tension when a compulsion is prevented or interrupted.

MANAGING DEPRESSION AND ANXIETY DISORDERS IN PERSONS WITH ID

When the conditions above result in significant distress and dysfunction, both pharmacotherapeutic and psychosocial approaches are employed to help the individuals suffering from the respective disorders. The use of medications follows similar guidelines for those in the general population, though it should be given cautiously because of the relatively high rate of unwanted adverse effects in persons with ID.⁸ Selective serotonin reuptake inhibitors (SSRI) are often the first-line treatment for depression and anxiety disorders; there has been a general agreement that doses used for treatment of depression/anxiety for persons with ID should be kept lower than normal and reviewed at regular intervals.⁹ Benzodiazepines are sometimes given as well on a PRN as-needed basis for short-term agitation or sleep disturbances, though again, care has to be taken due to higher incidences of adverse effects including paradoxical reactions in this population.

There may be an often-mistaken notion that psychotherapeutic interventions do not have much efficacy in the treatment of depression/anxiety for persons with ID due to their learning disability. However, evidence shows otherwise, e.g., studies in cognitive behavioural therapy (CBT) have showed it is just as effective for persons with ID, especially in those with just mild intellectual disability.¹⁰ Similarly, many simple psychological forms of help, e.g., psychoeducation, teaching relaxation techniques, and stress management skills can be effectively carried out. Caregiver and staff training to better help the people they are caring for is also highly recommended.

As persons with ID can become very anxious and feel threatened in the course of their daily activities by environmental stressors, a review of living conditions and daily activities may be necessary to ensure that factors that create inordinate stress can be reduced. In most cases,

especially for depression or GAD, these simple interventions can be done in the clinic setting, but referrals can be made to social service agencies with psychological or counselling services to assist as well.

REFERENCES

1. Cooper SA, Smiley E, Morrison J, Williamson A, Allan L. Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. *Br J Psychiatry*. 2007 Jan;190:27-35. doi: 10.1192/bjp.bp.106.022483. PMID: 17197653.
2. Emerson E, Moss S, Kiernan C. The relationship between challenging behaviour and psychiatric disorders. *Psychiatric and Behavioural Disorders in Developmental Disabilities and Mental Retardation*, Cambridge University Press, New York, NY. 1999 Jun 28:38-48.
3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th Edition. Arlington, VA: American Psychiatric Publishing; 2013.4. Szymanski LS, King B, Goldberg B, Reid AH, Tonge BJ, Cain N. Diagnosis of Mental Disorders in People with Mental Retardation. In *Psychotropic Medications and Developmental Disabilities: The International Consensus Handbook*. Ohio USA: Ohio State University Nisonger Center. 1998. p.3-17.
5. Deb S, Mathews T, Holt G, Bouras N. *Practice Guidelines for the Assessment and Diagnosis of Mental Health Problems in Adults with Intellectual Disability*. Brighton: Pavilion Publishing; 2001.
6. Chariot LR. Developmental effects on mental health disorders in persons with developmental disabilities. *Mental Health Aspects of Developmental Disabilities*. 1998;1:29-38.
7. Marston GM, Perry DW, Roy A. Manifestations of depression in people with intellectual disability. *J Intellect Disabil Res*. 1997 Dec;41 (Pt 6):476-80. doi: 10.1111/j.1365-2788.1997.tb00739.x. PMID: 9430051.
8. Stavrakaki C, Antochi R, Emery P. Obsessive compulsive disorder in adults with Down syndrome and other developmental disabilities. *Psych. Annals*. 2004;34:196-200.
9. Antochi R, Stavrakaki C, Emery PC. Psychopharmacological treatments in persons with dual diagnosis of psychiatric disorders and developmental disabilities. *Postgraduate Medical Journal*. 2003 Mar 1;79(929):139-46.
10. Lindsay WR, Neilson C, Lawrenson H. Cognitive-behaviour therapy for anxiety in people with learning disabilities. *Cognitive behaviour therapy for people with learning disabilities*. 1997:124-40.

LEARNING POINTS

- **Persons with Intellectual Disability (ID) can develop the same common psychiatric disorders as those without disability.**
 - **Assessing for psychiatric disorders includes an initial assessment of the behavioural concerns, looking out for the signs and symptoms that may present slightly differently in those with disability, and gathering more information from the caregivers.**
 - **Management of depression and anxiety disorders in persons with ID involves the usual biopsychosocial approaches in interventions for the individual, but it is also important to look into caregiver education and support.**
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