Four Factors Affecting the Diagnosis of Psychiatric Disorders in Mentally Retarded Persons

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One of the most difficult and important tasks to accomplish when evaluating mentally retarded persons who have emotional disorders is to differentiate diagnostically relevant from other forms of maladaptive behavior. For example, some retarded persons are diagnosed as suffering from schizophrenia or schizo-affective disorder because they appear to be disorganized and "out of control." As result of this diagnosis, they are likely to be treated with antipsychotic drug therapy. Such a clinical presentation is also consistent with an affective illness, however, or even with a transient reaction due to acute stress. If such non-specific disorganization is mistaken for a psychotic process, improper treatment and potentially serious adverse reactions (e.g., tardive dyskinesia) can be the result.

Many maladaptive behaviors which develop in mentally retarded persons are in fact nonspecific effects of developmental disabilities such as impaired communication skills. The Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) (4) does not take these effects into account, however, since it was designed to be used with mentally ill persons of normal psychosocial development. As a result, it is very difficult to use the DSM-III to diagnose psychiatric disorders in the mentally retarded.

Therefore, when evaluating a mentally retarded-emotionally disturbed individual, it is particularly important that the mental health clinician be able to "see past" the nonspecific effects produced by developmental disabilities and recognize the presence of illness specific symptoms and behavior (e.g., dysphoric mood in major depression).

Four Pathoplastic Factors

The term "pathoplastic" refers to the distorting effects of personality and intelligence upon the presentation of psychiatric disorders. In this article, we shall describe four pathoplastic factors which affect the diagnostic process when working with mentally retarded persons (16). The degree to which these factors modify the symptoms of psychiatric illness greatly depends on the severity of the developmental disabilities. The more severe the impairments, the greater their influence.

1) Intellectual Distortion

Intellectual distortion refers to the effects of the mentally retarded person's diminished ability to think abstractly and communicate intelligibly (2). Deficits in the ability to observe and describe one's own behavior and feelings severely hamper an individual's ability to report experiences which are consistent with a specific psychiatric disorder (e.g., suicidal thoughts which are a characteristic feature of major depression).

Mentally retarded persons may have any combination of speech impediments, limited vocabulary, concrete thinking, hearing deficits, and receptive and expressive aphasia, or they may completely lack any language function. Such disabilities make it especially difficult to diagnose psychotic disorders in clients with an IQ below 50, because they lack the communication skills necessary to describe hallucinations and delusions (2,5,13).
2) **Psychosocial Masking**

Because of their limited intellectual and social skills, mentally retarded persons are likely to have had less wide a range of life experiences than individuals of the same age with normal intelligence. This lack of real world experience affects the presentation of psychiatric disorders, including those in which delusions or hallucinations are present. We use the term **psychosocial masking** to refer to the concrete content and lack of imagination in symptom presentation.

Without a rich background of experience, the delusions of mentally retarded persons tend to resemble the fears of young children, rather than the detailed and imaginative belief systems that are generally associated with schizophrenia and mania. Typical manic grandiosity rarely occurs. Whereas the manic of normal intelligence may believe that he has the means to create world peace, the mentally retarded manic tends to believe he has skills above his developmental level. The grandiose content may go unrecognized unless the presence of mental retardation is taken into account: "When the normal person becomes manic, he thinks he's God. When the mentally retarded person becomes manic, he thinks he's not retarded (9)."

3) **Cognitive Disintegration**

Predisposed by organic deficits and concrete coping mechanisms, stress can cause a deterioration in intellectual functioning and a clinically significant behavioral regression (6,8). We use the term **cognitive disintegration** to describe this effect.

The process of cognitive disintegration is similar to that which occurs in pseudodementia. During an acute episode of a psychiatric illness such as an affective disorder, an elderly person, with compromised but compensated intellectual function, develops many of the signs of a full-fledged organic brain syndrome. This cognitive deterioration remits, however, when the acute psychiatric illness has been treated (1).

An analogous process may occur in mentally retarded persons who are exquisitely vulnerable to stress-induced intellectual and emotional decompensation (10). Stress may overload their cognitive functioning, and produce breakdowns in reality testing. As a result, the individual may become transiently psychotic and present with the signs and symptoms of a brief reactive psychosis in response to seemingly minimal stress. Vague paranoid ideas or mistaken perceptions may develop. "Autistic" behavior may be present. The patient may withdraw and talk to himself, creating or resurrecting an imaginary friend.

The effects of cognitive disintegration may be superimposed upon the features of a psychiatric illness, so that clinical presentation may be quite atypical. Visual hallucinations have been reported to occur in mentally retarded persons with mania (11) and depression (14). Penrose (11) believed that mentally retarded manics were more likely to hallucinate than their counterparts of normal intelligence, and Schneider (15) suggested that the mentally retarded have difficulty modulating strong negative affects and tend to hallucinate "through fear and anxiety."

Thus, a bizarre presentation in a mentally retarded patient has little diagnostic significance. It may not even indicate that a psychotic process is present.

4) **Baseline Exaggeration**

Mentally retarded persons have a variety of cognitive and psychosocial deficits such as distractibility and poor judgment. These are seen in the absence of any mental illness. In addition, they often develop maladaptive behaviors (e.g., self-injury) as attention-getting and demand avoidance maneuvers, or simply in response to a low-stimulus environment (in the case of profoundly retarded persons).

**Baseline exaggeration** refers to the fact that during a period of emotional stress, these deficits and maladaptive behaviors may significantly increase in severity. Thus, the signs and symptoms of a psychiatric illness may be a mix of new behaviors and an increase in severity of pre-existing ones, such as an increase in chronic, but usually infrequent, self-injury or aggression, or in the case of mania, an increase in the level of pre-existing distractibility and poor judgment.

Thus, in some cases, it is the exacerbation, rather than the onset, of behavioral problems which may be diagnostically relevant. This is of particular significance since the symptom criteria for
most DSM-III disorders represent qualitatively abnormal disturbances of psychological function. If the significance of changes in the severity of pre-existing problems is unappreciated, diagnostically relevant information will be missed.

Implications for Mental Health Clinicians

These four factors are of more than theoretical interest because they greatly affect the evaluation process for mentally ill—mentally retarded persons.

Limited Usefulness of the Clinical Interview

In psychiatry, the clinical interview is the primary tool for collecting diagnostic information (7). It is presumed that the patient can provide (with "prompts" from the clinician) most of the information needed to make a psychiatric diagnosis. When working with mentally retarded persons, this is usually not the case.

Through an interview, the clinician can assess a client's activity level and determine the degree of stress the person is experiencing. Except with some mildly retarded individuals, however, it is usually difficult if not impossible to elicit enough information regarding past experiences and present functioning to make a clearcut diagnosis.

This means that the mental health clinician must rely on information from care givers, family members, and treatment records. Thus, during an initial evaluation the clinician might spend 15 to 45 minutes interviewing the client and 60 to 120 minutes meeting with family and various staff from the agencies which serve the client. In addition, the initial consultation might lead to subsequent meetings to review new data.

For example, a depressed person of normal psychosocial development can easily state whether or not awakening during the middle of the night is a problem. When working with a mentally retarded person, however, the consultant (if depression is suspected) might have to ask that the client be checked during the night to see if he is awake.

Inadequacy of Current DSM III Criteria

Since the DSM-III is designed to be used with patients of normal intelligence, the clinical features which must be present are often difficult to detect in the mentally retarded person (13). This means that the presence of a DSM-III diagnosis may have to be inferred on the basis of global presentation rather than the presence of specific criteria.

This does not mean that the principles inherent in the use of DSM-III diagnoses do not apply to the mentally retarded. The concept that psychiatric disorders form discrete syndromes with characteristic emotional complaints and behavior is equally relevant to individuals with developmental disabilities (see P.A.M.R. Reviews, December, 1984), but the specific features which are used to make a diagnosis must take into account the four factors described in this article.

References

1 Caine E. Pseudodementia. Arch Gen Psychiatry 38:1359-1364, 1981.


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Upcoming Conferences of Mental Illness — Mental Retardation

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International Research Conference on the Mental Health Aspects of Mental Retardation sponsored by the Department of Psychology, University of Illinois at Chicago. For more information contact Professor Steven Reiss, Department of Psychology, University of Illinois at Chicago, P.O. Box 4348, Chicago, IL 60680, (312) 996-3036.
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<tr>
<th>Factor</th>
<th>Definition</th>
<th>Clinical Impact</th>
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<td>1) Intellectual Distortion</td>
<td>Effects of concrete thinking and impaired communication skills</td>
<td>Results in the inability of patient to label own experiences and report them.</td>
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<td>2) Psychosocial Masking</td>
<td>Effects of impoverished social skills and life experiences</td>
<td>Unsophisticated presentation and lack of poise during interview can result in missed symptoms and misattribution of nervousness and silliness as psychiatric features.</td>
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<td>3) Cognitive Disintegration</td>
<td>Effects of stress-induced disruption of information processing</td>
<td>Bizarre presentation and psychotic-like state may be misdiagnosed as schizophrenia.</td>
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<td>4) Baseline Exaggeration</td>
<td>Increase in severity of pre-existing cognitive deficits and maladaptive behaviors due to a psychiatric disorder.</td>
<td>Creates difficulty in establishing illness features, target symptoms, and outcome measures.</td>
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