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Discovery of previously undetected intellectual disability by psychological assessment: A study of consecutively referred child and adolescent psychiatric inpatients[☆]



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ABSTRACT

Intellectual disability is associated with an increased risk of behavioral disturbances and also complicates their treatment. Despite increases in the sophistication of medical detection of early risk for intellectual disability, there is remarkably little data about the detection of intellectual disability in cases referred for psychiatric treatment. In this study, we used a 10-year sample of 23,629 consecutive child and adolescent admissions (ages between 6 and 17) to inpatient psychiatric treatment. Eleven percent ($n = 2621$) of these cases were referred for psychological assessment and were examined with a general measure of intellectual functioning (i.e., WISC-IV). Of these cases, 16% had Full Scale IQs below 70. Of the cases whose therapists then referred them for formal assessment of their adaptive functioning (i.e., ABAS-II) 81% were found to have composite scores below 70 as well. Only one of the cases whose Full Scale IQ was less than 70 had a referral diagnosis of intellectual disability. Cases with previously undetected intellectual disability were found to be significantly more likely to have a diagnosis of a psychotic disorder and less likely to have a diagnosis of mood disorder than cases with IQs over 70. Disruptive behavior disorder diagnoses did not differ as a function of intellectual performance. These data suggest a high rate of undetected intellectual disability in cases with a psychiatric condition serious enough to require hospitalization and this raises the possibility that many such cases may be misdiagnosed, the basis of their problems may be misconceptualized, and they may be receiving treatments that do not take into account their intellectual level.

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Behavioral disturbances are common in individuals with intellectual disabilities (Allen, 2008; Einfeld, Ellis, & Emerson, 2011). These disturbances include aggression toward others, self-injurious behaviors, extreme or erratic changes in mood and stereotyped behaviors (Emerson, 2003; White, Chant, Edwards, Townsend, & Waghorn, 2005). It has been argued that these are more common in children than adults (Whitaker & Read, 2006), and an extensive empirical literature addresses the management of these behavioral disturbances through pharmacological and behavioral interventions (Oliver & Richards, 2010; Pandina et al., 2007). In addition, there are major efforts underway to identify individuals who are at increased risk for intellectual disability, including even in-utero assessments of individuals who are at high risk for various developmental syndromes (e.g., fragile-x; Down's syndrome, etc.) that are accompanied by intellectual disability (Driscoll & Gross, 2009; Grosse & Van Vliet, 2011; Lubs, Stevenson, & Schwartz, 2012).

There is also a considerable literature on the impact of psychiatric syndromes on intellectual functioning, particularly the impact of schizophrenia and bipolar disorder on a variety of cognitive processes (Woodberry, Giuliano, & Seidman, 2008). However, most of these studies have related information from records to the development of psychosis at a later date, not in childhood, and the average scores of these populations suggest that very few would be identified as intellectually disabled. Intellectual deficiency is an exclusion criterion for many psychiatric conditions and would be expected to be of low prevalence in cases that had been carefully assessed. Einfeld and Tonge (1996) reported 40.7% of individuals with intellectual disability also met criteria for psychiatric disorders. Another study found 31% of individuals with intellectual disability also met criteria for Axis I psychopathology; among this group 43.9% had more than one diagnosis (Clay & Thomas, 2005). In a review of nine published studies, Einfeld et al. (2011) found prevalence rates between 30% and 50% of comorbid mental illness among children and adolescents with intellectual disability. Another study of children with intellectual disability found that about 50% of participants exhibited emotional and behavioral problems on the Child Behavior Checklist (CBCL) and Teacher's Report Form (TRF) (Dekker, Koot, Ende, & Verhulst, 2002). It is clear that in individuals with identified intellectual disabilities or risk factors for intellectual disability the assessment of mental health status and treatment of comorbidities is critical (Dykens, 2000; Einfeld et al., 2011; Hodapp & Dykens, 2009).

An issue that has been less well addressed is the extent to which individuals who are receiving treatment for behavioral disturbances, have received formal psychiatric diagnoses, and are being treated for those conditions have impaired intellectual functioning that has not previously been detected. It is unclear how many children and adolescents who receive mental health services have undetected intellectual deficiencies. The failure to identify such individuals is important, as problematic behaviors (e.g., impulsivity, aggression, etc.) and psychiatric symptoms (i.e., anxiety, agitation, etc.) may have entirely different causes in intellectually deficient children and adolescents than they have in their intellectually normal peers, and they may respond to entirely different treatments. This is particularly important since treatments with high side-effect potential are being regularly used to address these symptoms and problems (Matson & Mahan, 2010). If intellectual deficiency is not identified, maladaptive behaviors, poor judgment, and emotional distress may be attributed to mood disorders, psychotic disorders, or anxiety disorders, when these are better understood as the product of the mismatch between the individual and the demands and expectations of the home, school, or social environments. For many psychiatric disorders cognitive functioning is among the strongest predictors of functional outcome (Heaton & Pendleton, 1981) and learning more effective behaviors and implementing them at appropriate times is central to many common interventions. For these reasons, impairment in intellectual functioning would be expected to have a negative impact on many interventions and increase the risk that people receiving these interventions will be considered to be "treatment resistant" or "treatment nonresponsive". While the sparse literature on Cognitive Behavioral Therapy (CBT) augmentation of antidepressant treatment in adolescents with treatment resistant depression (reviewed by Hetrick, Cox, & Merry, 2011) suggests no additional benefit of learning based therapies, there is no mention of using performance-based assessment of intellectual disability as an exclusion criterion. If a significant percentage of the children and adolescents receiving mental health services have undetected intellectual limitations is entirely possible that these might have interfered with this kind of learning based intervention.

There is little evidence in the literature of any attempts at systematic performance-based screening for intellectual disability in treatment facilities aimed at psychiatric conditions. In fact, intellectual disability researchers have indicated that there is no currently validated scale to efficiently screen for the presence of these disabilities (McKenzie & Megson, 2012). Unfortunately, the costs and time demands involved in conducting a full intellectual assessment on most or all of the patients presenting to any treatment setting are likely to make this impractical.

In this paper, we present the results of an examination of a large consecutive series of children and adolescents admitted to the inpatient services of a large private psychiatric hospital who were referred for intellectual and psychological assessments. Over 2500 of these referrals were made over a 10 year period and the rate of detection of Full Scale IQ and Index scores less than 70 was examined. Only two of the more than 2500 cases referred for psychological assessment were identified as intellectually deficient or carried a diagnosis of mental retardation at the time of admission. A subset of these cases also received a full functional assessment as required to substantiate the presence of adaptive deficits consistent with a diagnosis of intellectual disability (i.e., DSM-IV mental retardation) and we present that information as well. Finally, we report on the proportion of cases where definitive evidence of intellectual disability was detected and this information was reflected in their discharge diagnoses.

1. Methods

Participants: This is an archival review of data on psychiatric inpatients between the ages of 6 and 17 at the time of their admission to a private psychiatric hospital in Westchester County, New York. The patients who underwent psychological

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