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Prevalence of psychiatric symptoms in adults with mental retardation and challenging behaviour

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Abstract

The relation between psychiatric symptoms and different types of challenging behaviour in adults with mental retardation was investigated, using an instrument designed for use by non-specialist informants. A sample of 165 persons with mental retardation was surveyed for the presence of psychiatric symptoms, level of mental retardation, and self-injurious and other types of challenging behaviour. Challenging behaviour was associated with increased prevalence of psychiatric symptoms, especially anxiety and psychosis, less with hypomania, and not with depression. No association between anxiety and self-injurious behaviour was found. An association between psychiatric symptoms and challenging behaviour on a group level is an initial step towards understanding causes of challenging behaviour. Issues remain, like how causation takes place on an individual level, and the nature of psychiatric disorders in persons with severe and profound mental retardation.
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1. Introduction

A relatively large proportion of persons with mental retardation show problematic behaviours like self-injurious behaviour, aggression towards others, destruction of property, inappropriate social and sexual conduct, screaming,

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non-compliance, and eating inedible objects. The behaviours may be dangerous to the individual, problematic for caregivers or staff, or unacceptable to the public. Especially the latter depends on the cultural and social context. These behaviours are covered by the umbrella term *challenging behaviour* (Emerson, 2001). Several studies have investigated the prevalence of challenging behaviour among persons with mental retardation. Borthwick-Duffy (1994) identified 14% of the population with mental retardation as having challenging behaviour. Quereshi and Alborz (1992) found that 5.7% of the population with mental retardation manifested severe challenging behaviour. Based on a recent review of the literature, Emerson et al. (2001) concluded that challenging behaviours are shown by 10–15%, and that more challenging behaviours are shown by 5–10% of persons with mental retardation who receive educational, health or social care services for people with mental retardation.

In addition, the prevalence of psychiatric disorders is higher among people with mental retardation compared with the general population (Pyles, Muniz, Cade, & Silva, 1997). Until about 20 years ago, psychiatric symptoms in persons with mental retardation could still be understood as an inherent aspect of mental retardation, i.e., "diagnostic overshadowing". More recently, this has been replaced by the concept *dual diagnosis*. Most researchers agree that there is little qualitative difference between the presentation of psychiatric disorders in people with mild and moderate mental retardation and in the general population (Sturmey, 1999). However, psychiatric disorders in persons with severe and profound mental retardation may be more difficult to detect. Limited verbal reports and generally restricted behaviour repertoires make it more complicated to distinguish possible psychiatric symptoms from developmentally normal behaviour. Also, deviant speech or social withdrawal may have been present for most of the person's life.

The failure of persons particularly with severe and profound mental retardation to meet DSM-IV criteria (American Psychiatric Association, 1994) has lead to the development of different diagnostic instruments for psychiatric disorders in persons with mental retardation. Most of them are designed for completion by third-party observers. The symptomatology is a little simplified, and the number of possible diagnoses are somewhat reduced. The instruments most frequently used are Reiss screen (Reiss, 1987), Psychopathology Inventory for Mentally Retarded Adults (PIMRA) (Senatore, Matson, & Kazdin, 1985) and Diagnostic Assessment of the Severely Handicapped (DASH) (Matson, Gardner, Coe, & Sovner, 1991). The Psychiatric Assessment Schedule for Adults with a Developmental Disability (PAS-ADD) exists in three versions: PAS-ADD Interview (Moss et al., 1993), which requires that the patient is verbally able, and PAS-ADD Mini (Prosser et al., 1998) and PAS-ADD Checklist (Moss et al., 1998), which are screening instruments, aimed at enabling caregivers and staff to make more accurate referral decisions for further diagnostic examinations by psychiatrist or psychologist. Checklist is the simplest one, with a list of 29 symptoms. In general, the various instruments' diagnostic validity has been found to be acceptable (Sturmey, 1999).

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