DEPRESSION IN ADOLESCENTS WITH MENTAL RETARDATION: A CLINICAL STUDY

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Introduction

Mental retardation (MR) has often been considered an intellectual impairment principally requiring educational or social interventions; hence, the psychiatric dimension of the problem has been neglected (Potter, 1971). This is particularly true for children and adolescents with MR (Masi et al., 1996).

The impact of MR on personality development is confirmed by psychopathological vulnerability of people with MR (Masi, 1997). According to the DSM-IV (American Psychiatric Association, 1994), all the types of mental disorders can be observed in these subjects, with a prevalence estimated to be at least 3 or 4 times higher than in the general population. Rutter et al. (1970) in their epidemiological study in the isle of Wight examined psychiatric and behavioural problems in all 9 and 10 year old with IQ under 70, screened by group IQ test, then assessed with individual WISC (Weschler, 1974) (59 subjects). They used standardised parent and teacher rating scales together with child psychiatric interview. A parent questionnaire revealed psychiatric disorders in 30% of low IQ children and in 8% of control (children with normal intelligence levels), with a teacher questionnaire psychiatric problems were found in 42% of low IQ children and in 10% of controls; using child interview psychiatric disorders were found in 24% of low IQ children and in 1.4% of controls. Incidence rates were similar among non institutionalised subjects in Sweden (Gillberg et al., 1986).

People with MR can experience the full range of affective disorders (Sovner and Hurley, 1983; Dosen and Gielen, 1993). The prevalence of depressive disorders is unclear, because cognitive impairment can mask the emotional disturbance (the so-called diagnostic overshadowing) (Reiss, 1999).

A crucial problem in depressive disorders of children and adolescents with MR has to do with the diagnostic criteria and the clinical features. DSM IV criteria for mood disorders (American Psychiatric...
Association, 1994) seems to consent reliable diagnosis in subjects with mild MR (Pawlarcyk and Beckwith, 1987). In severe MR, modifications to the current diagnostic criteria are needed (Sovner, 1986). Furthermore, the use of rating scales (self-report or other-report rating scales) can yield a more detailed identification of typical symptoms of depressive disorder in people with MR (Masi et al., 1997).

The clinical characteristics of depressive disorders are strongly influenced by the intellectual disability (Eaton and Menolascino, 1982). Clinical features are often not well defined, symptoms are more specific as the intellectual impairment becomes more severe. Hence, diagnosis can be particularly difficult. The longitudinal course of depressive disorders often differs from that of corresponding disorders in subjects with normal intelligence; for example, the remission of symptomatology is less frequent in MR. The role of traumatic life events is especially important, as they have a triggering effect more frequently in subjects with MR than in subjects with normal intelligence levels. Principal aim of this paper is to provide some information about assessment and clinical features of depressive disorder in a group of adolescents with mild MR.

The high percentage of depressed adolescents (25% on the whole sample) can be justified because people with MR came for consultation for emotional and/or behavioural problems and not for problems of intellectual disability. Therefore, they are not a representative sample of the general population of people with MR (Masi et al., 1997).

The age range of the subjects (10 males and 5 females) was 14.0-19.2 (mean age 16.2). 4 subjects had Down syndrome, 1 had Prader-Willie syndrome, 2 had X-fragile syndrome, 3 subjects had brain lesions (perinatal damage), 5 subjects had a so-called familiar MR without known etiology. No subject were on psychotropic drugs during the assessment. No subject has taken anti-depressants before this study.

b) Instruments

The 15 subjects were classified according to the DSM IV diagnostic criteria (American Psychiatric Association, 1994) as suffering from Major Depressive Disorder. A rating scale for depression, the Montgomery-Asberg Depression Scale (MADRS) (Montgomery and Asberg, 1979; Masi et al., 1997) was administered to all the subjects.

The MADRS explores ten areas of the depressive symptomatology:

1. Apparent sadness
2. Reported sadness
3. Inner tension
4. Reduced sleep
5. Reduced appetite
6. Concentration Difficulties
7. Lassitude
8. Inability to feel
9. Pessimistic thoughts
10. Suicidal thoughts

Method

a) Sample

From the Outpatient Department based at the Institute of Developmental Neurology and Psychiatry and Educational Psychology of the University of Pisa, a group of 60 adolescents with MR were consecutively screened for psychiatric disorders; 15 adolescents fulfilled the DSM IV criteria for depressive episode (American Psychiatric Association, 1994).
In each area the severity of the illness can be rated on a seven point scales (from 0 to 6), on the basis of a clinical assessment of the subject and/or descriptions by parents or informed others. The global severity of the depressive illness can be inferred from the total score. The assessment can be repeated for retests.

The same child psychiatrist administered the MADRS (Montgomery and Asberg, 1979) to all the subjects.

Results

The subjects were evaluated according to both DSM IV criteria (American Psychiatric Association, 1994) and MADRS (Montgomery and Asberg, 1979). All the subjects with major depressive episodes, according to the DSM IV criteria, had a high score on the MADRS, 28 or more, a value that is strongly indicative of depressive disorder.

A descriptive analysis of the depressive symptoms in our sample, as they were assessed according to the diagnostic criteria of DSM IV (American Psychiatric Association, 1994), showed some recurrent patterns (FIGURE 2).

All the subjects presented depressed mood (in four subjects irritability was also present), psychomotor agitation or retardation, loss of energy. 11 subjects showed a diminished interest for almost all the activities. 7 had disturbed sleep, 5 reduced appetite, 5 diminished ability to think or concentrate, 5 had feelings of worthless-
FIGURE 2
Depressive Symptoms, According to DMS IV Criteria

FIGURE 3
Mean Score of MADRS Items
A descriptive analysis of the MADRS protocol (Montgomery and Asberg, 1979) showed similar features (FIGURE 3). The means of the scores for each area are evident in the Figure:

1. Apparent sadness: 4.5
2. Reported sadness: 3.2
3. Inner tension: 4.2
4. Reduced sleep: 2.7
5. Reduced appetite: 2.2
6. Concentration difficulties: 2.5
7. Lassitude: 4.1
8. Inability to feel: 3.5
9. Pessimistic thoughts: 2.5
10. Suicidal thoughts: 1.5

Discussion

Children and adolescents with MR are considered particularly vulnerable to depression (Reynolds and Miller, 1985). Diagnosis of major depressive disorder in these special populations is often difficult, because of deficit of language expression and comprehension and insight, and the peculiarity of clinical expression of depressive disorder in this population. This issue is related to the essence of psychopathology in people with MR: do psychopathological phenomena in people with MR correspond to similar phenomena in normal IQ subjects? Are there peculiar emotional-behavioural disturbances in people with MR? Can main nosological categories of DSM IV (American Psychiatric Association, 1994) be applied to MR? Are these clinical pictures present for all levels of severity of MR? How does the level of MR affect the expression of these clinical pictures (Aman, 1991)?

These aspects must be kept in mind when we evaluate reliable assessing instruments for psychiatric disorders in people with MR. Some of these instruments were specifically created for developmentally delayed persons; other diagnostic tests were originally developed for normal IQ subjects, and then used for people with MR. Some instruments were mainly developed for evaluating and describing maladaptive behaviours, others aimed to obtain diagnosis according to the most important nosographic systems.

Any diagnostic procedure should explore a broad range of affects and emotions, behaviourally defined whenever it is possible, together with an other-report completion by caretakers (Feinstein et al., 1988). In children and adolescents with MR careful exploration of the course of developmental process is needed.

Several studies reported low correlations between self-report and other report depression rating scales in people with MR. Subjects and informants probably report different aspects of depressive symptomatology, more cognitive for the subjects (guilt, hopelessness), more behavioural (crying, irritability) for the informants (Kazdin et al., 1983). The importance of using both self-report and other report measures in person with MR is crucial, as these subjects may have difficulty in reporting depressive states.

Our preliminary data on a small sample of adolescents with mild MR with depression seem to indicate that DSM IV criteria (American Psychiatric Association, 1994) and MADRS (Montgomery and Asberg, 1979) are coherent and reliable diagnostic instruments. A descriptive analysis of these protocol suggests that some depressive symptoms are more frequent than others, specifically depressed mood, psychomotor agitation or retardation and loss of energy and interest. Our data indicate that cognitive symptoms (depressive ideation) and functional symptoms...
(disturbed sleep, appetite, etc.) are less frequent than emotional symptoms (sadness, inner tension) and psychomotor symptoms.

Apparent sadness is significantly more represented than referred sadness. Inner tension is a form of anxiety expressed by discomfort, edginess, internal turmoil that the subject cannot conceptualise or verbalise. Psychomotor symptoms are often mixed: lassitude and loss of energy can co-exist with episodic psychomotor agitation. The reduced interest in surroundings and/or activities is expressed by a reduction in emotional reaction to circumstances.

This configuration of symptoms, although in themselves non specific, must be kept in mind; they can represent a risk factor for more serious psychopathology and/or for maladaptation in social and interpersonal functioning.

Summary

The aim of this paper is to provide some information about assessment and clinical features of depressive disorder in a group of mildly mentally retarded depressed adolescents. 15 mildly mentally retarded adolescents (10 males and 5 females, age range 14.0-19.2, mean age 16.2) fulfilled the DSM IV criteria for depressive episode. An other-report rating scale for depression, the Montgomery Asberg Depression Rating Scale (MADRS) was administered to all the subjects of the sample. All the subjects that met DSM IV diagnostic criteria had at the MADRS a score strongly indicative of depressive disorder. A descriptive analysis of the DSM IV diagnostic criteria and MADRS protocol seems to indicate that some depressive symptoms are particularly frequent; cognitive symptoms (depressive ideation) and functional symptoms (disturbed sleep, appetite, etc.) are less frequent than emotional symptoms (sadness, inner tension) and psychomotor symptoms.

References


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