

PERSONALITY DISORDERS IN LEARNING DISABILITY - THE CLINICAL EXPERIENCE

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Introduction

Diagnosing personality disorders in those with learning disability remains a rather contentious issue. A recent review pointed out the inherent difficulties in this area (Alexander and Cooray, 2001). Difficulties in eliciting the information necessary for the diagnosis, appropriateness of applying some of the current diagnostic criteria and the overlap between characteristics of the person's learning disability itself and some of the personality disorder criteria are some of the main issues discussed in literature.

Difficulties in communication and the prominence of physical, sensory and other behavioural disabilities cause problems in assessment (Khan *et al.*, 1997). Likewise, certain behaviours, which may be intrinsic to the person's learning disability, may resemble some of the ICD 10 (WHO, 1992) or DSM IV (American Psychiatric Association,

1994) criteria for personality disorders (Alexander and Cooray, 2001). Thus some criteria for Emotionally Unstable Personality Disorder (eg. '*marked tendency to act unexpectedly and without consideration of the consequences*', '*difficulty in maintaining any course of action that has no immediate reward*') may be satisfied by a substantial proportion of people with learning disability. Likewise, it may be difficult to apply criteria for dependent personality disorder (eg. '*allowing others to make most of one's important life decisions*', '*undue compliance with other's wishes*', '*limited capacity to make everyday decisions without excessive amount of advice and reassurance from others*') to those people who, because of their developmental disability, have realistic dependency needs (Reid and Ballinger, 1987).

The introduction of structured instruments like Standardized Assessment of Personality (Mann, 1981; Ballinger and Reid, 1987) has been a helpful develop-

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ment. Although initial studies using this instrument were limited to people with mild and moderate learning disabilities (Reid and Ballinger, 1987; Deb and Hunter, 1991), subsequently it has been used across the whole range of intellectual ability (Khan *et al.*, 1997; Goldberg *et al.*, 1995; Flynn *et al.*, 2000). Some of these studies revealed exceptionally high prevalence rates of up to 90% for different types of personality disorders in learning disability (Goldberg *et al.*, 1995). This study which had a sample size of 384 patients drawn from both community and hospital settings showed that only 9% of those in the community and 43% of those in institutions did not satisfy DSM III diagnostic criteria (American Psychiatric Association, 1987) for one of the personality disorder clusters. The relationship of the specific clusters of personality disorders to later onset of psychiatric disorders was also explored.

The ultimate validity of any diagnosis is in its clinical usefulness. Not surprisingly therefore, unusually high prevalence rates would raise questions regarding the usefulness of such a diagnosis, particularly in those with severe or profound learning disabilities. Whatever the controversies surrounding the process, the diagnosis of personality disorders in learning disability remains a significant issue. This is because it may affect a person's acceptance into community placements (Reid and Ballinger, 1987), predict subsequent psychiatric disorders (Goldberg *et al.*, 1995), determine the rate of referral to specialist services (Khan, *et al.*, 1997) and influence the mode of treatment (Hurley and Sovner, 1995; Mavromatis, 2000; Wilson, 2001).

Anecdotal evidence would suggest that the diagnosis of personality disorders within routine clinical practice in learning disability happen much less often than some of the high figures mentioned in literature

This paper describes a sample drawn from a baseline audit of the psychiatric caseload of a defined geographical area in Leicestershire, UK. It looks at the prevalence of personality disorders in learning disability and describes the socio demographic and clinical variables.

Method

The active outpatient caseload of two consultant psychiatrists in learning disability in Leicestershire, UK was screened as part of a baseline audit. Those with a diagnosis of personality disorder mentioned in the psychiatric case notes were identified. Using information from the case notes and their personal knowledge of the patients, the responsible clinicians then applied ICD 10-DCR (WHO, 1993) criteria for personality disorders. Most of the patients had a long history of persistent maladaptive behavioural patterns starting from childhood or adolescence. Examples include repeated impulsive behaviours like self-harm, aggressive behaviours and unstable and intense relationship followed by rejection in people with borderline personality disorder and tendency for violence without remorse, lying and other seriously irresponsible behaviour in those with disocial personality disorder. Socio-demographic and clinical details including service utilisation were collected systematically using a proforma designed for this audit.

Findings

The total population in the specified area was 445,000 of which 430 people were on the outpatient caseload of the psychiatry team. Twenty nine patients had a clinical diagnosis of personality disorder, thus giving a prevalence of 7%. The mean

age of the sample was 38 years (SD 11) and the range 22 to 67 years. There were 16 females (55%) and 13 males (45%). Four (14%) were living in NHS placements, 16 (55%) in private residential group homes and 9 (31%) either with their family or on their own.

Two (7%) had borderline intellectual functioning, 23 (79%) had mild and 4 (14%) had moderate learning disability. There was no one with severe or profound learning disability. In 24 patients, the cause of learning disability was unknown, while in 5 it was thought to be the result of prematurity or complications of labour. One had Wilson's disease.

Five people (17%) had epilepsy. Looking at the psychiatric co-morbidity, 10 (34%) had a mental illness along with personality disorder. This was made up of 8 (28%) with major affective disorders (bipolar disorder or recurrent depression), 1 with a psychotic illness and 1 with anxiety disorder. Twenty (69%) had a history of violent behaviour and 7 (24%) had sexually inappropriate behaviour.

On applying ICD-10 DCR, all the 29 patients with a clinical diagnosis of personality disorder satisfied criteria for at least one of the specific personality disorder categories. Seventeen (59%) were dissocial, 8 (28%) emotionally unstable, 3 (10%) both dissocial and emotionally unstable and 1 (3%) had an anxious personality disorder.

Psychotropic medication was used in most of the subjects; 25 (86%) were on anti-psychotics, 13 (45%) on antidepressants and 10 (35%) on mood stabilisers. Regarding the utilisation of mental health services, 17 (59%) had one or more admissions to the hospital's in-patient unit over the last 5 years. Two of these subjects stayed for over a year. A specialist outreach team which provided intensive behavioural support

was involved with 17 (59%), community nurses with 20 (69%) and other support workers with 19 (66%) subjects.

Discussion

Previous studies have highlighted the difficulties in the assessment and diagnosis of personality disorder as the level of learning disability increases (Ballinger and Reid, 1988; Gostason, 1985). The findings from this study that, although the patient caseload of this service is made up predominantly of those with moderate or severe learning disability, the *clinical* diagnosis of personality disorder is limited to those with mild or borderline intellectual disability. It seems that in day to day clinical practice, a diagnosis of personality disorder is considered only for a small minority who have reasonable cognitive and verbal abilities, but present with severe behavioural and emotional problems requiring significant support from professionals. This is supported by the fact that the majority of these patients, in spite of having borderline intellectual functioning or a mild degree of learning disability, still live in residential placements with high staffing ratios (NHS or private homes). Although only one third of the sample had a mental illness in addition to personality disorder, the vast majority of them were on psychotropic medications and receives input from a large number of professionals.

One could perhaps argue that the prevalence figure of 7% underestimates the true prevalence of personality disorders in learning disability. However, this is probably a more accurate reflection of day to day clinical practice and it is worth noting that all patients identified in this manner satisfied the rigorous ICD-10 research crite-

ria (WHO, 1993). This shows that the *clinical* diagnosis does have a high degree of specificity.

All except one in this sample had either a dissocial or an emotionally unstable personality disorder. Although the finding from a previous study showed that these two disorders are more likely to be referred to community learning disability services (Khan *et al.*, 1997), this alone is unlikely to explain the unusually low prevalence of other personality disorders in this study. One could speculate that these two disorders are likely to attract a diagnosis of personality disorder by the sheer intensity of the problem that is presented. Other personality disorders like anxious, dependent or schizoid are more likely to be attributed to the effect of learning disability itself or associated morbidity like autistic spectrum disorders. The person with the anxious personality disorder in this sample had a mild learning disability and good verbal skills and the latter did help in establishing the diagnosis.

There is no consensus on the applicability of the criteria of the full range of personality disorders across the whole spectrum of learning disability. Although a significant proportion of people with moderate or severe learning disability may satisfy many criteria for personality disorders, a definitive diagnosis may not be possible due to the inability to elicit information about their inner mood states, experiences or belief systems. Indeed, if diagnostic criteria are applied in such a way that an overwhelming majority of those with learning disability satisfy the criteria for personality disorders, it is not of much clinical use, either for the management of the individual patient or the planning of services.

One way forward is to adapt the diagnostic criteria to the developmental level of the individual when it is applied to people

with learning disabilities. In the absence of such norms, the current clinical practice of limiting the diagnosis of personality disorder to a tightly defined group may make more sense, as it identifies a group of people with specific care needs or resource implications.

This study shows that the level of support that is required by this group of people differentiates them quite markedly from other patients with similar level of disability. Indeed there are case reports showing how current services struggle to support this group (Sultan, 2001)¹. This highlights the importance of understanding the needs of this population to develop appropriate services.

Summary

The diagnosis of personality disorders in learning disability is often contentious. Some studies showing exceptionally high prevalence rates for these disorders have raised questions about its clinical usefulness in learning disability. This study aims to estimate the prevalence of a clinical diagnosis of personality disorder among those with learning disability and mental health or behavioural problems and describe their characteristics. People with a clinical diagnosis of personality disorder were identified by screening the psychiatric casenotes of patients from two areas of Leicestershire. ICD-10 DCR (WHO, 1993) criteria were then used to identify the type of personality disorder. Socio-demographic and clinical details were collected using a semi-structured proforma. Twenty nine out of the 430 patients seen by two consultant psychiatrists had a clinical diagnosis of personality disorder, thus giving a prevalence of 7%. The vast majority had either mild or borderline learning disability. Only 34% had a co-morbid mental illness, but the

vast majority were on psychotropic medication. Fifty nine had an history of hospital admissions and 59% needed active support from an outreach team. Some recent studies in learning disability have suggested prevalence figures up to 90% for personality disorders. The prevalence figure of 7% from this survey suggests that in routine clinical practice, the diagnosis is limited to those with mild learning disability and significant behavioural disruption. Those diagnosed in this manner also satisfy the rigorous ICD 10-DCR criteria (WHO, 1993). To diagnose personality disorders across the whole range of learning disability, diagnostic criteria that are specific for different developmental levels are needed. In the absence of such norms, the current clinical practice of limiting the diagnosis of personality disorders to a tightly defined group may make more sense, as it identifies a group of people with specific care needs and resource implications.

Footnote

1) Sultan, K. (2001). Management of people with learning disability and personality disorder. *Poster presentation at the II Annual Meeting of the British Irish Group on Personality Disorders (BIGSPD)*, Leicester, 31 January-2 February 2001. Further information can be obtained by contacting Dr. Gangadharan.

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