

PSYCHIATRIC DISORDER IN ADULTS ADMITTED TO A HOSPITAL FOR THE MENTALLY HANDICAPPED

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INTRODUCTION

Psychiatric symptoms and illness is known to be common in hospitals for the mentally handicapped (DHSS 1972; Williams 1971). Descriptions of psychotic illness that occur in the mentally handicapped, both functional and organic, have been presented by Reid (1972 a & b) and Reid and Augle (1974). The prevalence of psychiatric illness in the mentally handicapped has been reviewed by Pilkington (1972) who felt that there was a need for accuracy and standardised assessment for comparative studies. Many standardised assessments already existed, but concentrate on the degree of mental handicap rather than on psychiatric symptoms or illness (Gunzburg 1968; Kushlick *et al.* 1973). A method of standardised assessment arose by using the standardised psychiatric interview for use in community studies (Goldberg *et al.* 1970) and then modifying it for use with the mentally handicapped (Ballinger *et al.* 1975). It was shown that this modified version of the Goldberg standardised interview was valid, reliable and applicable for use with the mentally handicapped (Ballinger *et al.* 1975).

Ballinger and Reid (1977) used this modified version of Goldberg's standardised interview to compare psychiatric disorder in 75 patients at an adult training centre and 75 patients in a hospital for the mentally handicapped. They showed that ten of the adult training centre patients were in the pathological range for psychiatric symptoms compared to 23 of the inpatients. The present study is a description of psychiatric symptoms in adult patients admitted to Gogarburn Hospital in the six month period October 1981 to March 1982.

METHOD

53 Adult patients consecutively admitted to Gogarburn Hospital in the six months period from October 1981 to March 1982 were all interviewed. 32 of these patients were admitted to hospital for short periods of respite ranging from a few days to several weeks. The remainder were admitted either for inpatient assessment or treatment of a specific clinical problem, for example, behavioural disturbance or for longer term care. Each patient was interviewed on one occasion only, despite several patients being readmitted for further periods of respite. The aim of the interviews was to ascertain the prevalence of psychiatric symptoms in this group of individuals, the majority of whom lived in the community.

The technique employed was that described by Ballinger *et al.* (1975), of the modified Goldberg standardised interview. For patients with adequate verbal skills, there are thirteen symptoms rated on a five point scale. All individuals, regardless of verbal skills, were rated for seventeen manifest abnormalities, again on a five point scale. Finally, there was a rating of overall severity on a five point scale. 0 rating indicates absence of a symptom and a rating of 1 is indicative of a habitual trait or "borderline" symptom. Ratings of 2, 3 or 4 indicates mild, moderate and severe degrees of clinical severity of a particular symptom.

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RESULTS

The mean age of the male admissions was 31.3 years and of females 40.5 years. Table 1 shows the degree of handicap. It was possible to rate symptoms (Table 2) in 23 of the male admissions and 16 of the female admissions. In both men and women depression, irritability and anxiety are quite common, but phobias was by far the most frequent symptom. Depression was the most common manifest abnormality in both men and women (Table 3).

Breakdown of the phobias (Table 4) indicates that the various phobias are fairly evenly spread through the female patients and that fear of the dark is the commonest phobia to both male and female patients.

Overall ratings (Table 5) indicate that six male patients ($\approx 16.5\%$) and five female patients ($\approx 25\%$) scored in the 2 - 4, i.e. pathological range.

DISCUSSION

In the population interviewed, phobias appears to be the dominant symptom with approximately 57.5% of the patients scoring in the 2 - 4 range. Fear of the dark was the commonest phobia for male and female patients. The other phobias in Table 4 were also quite common, especially in female patients. This was a descriptive study and conclusions must be tentative. It would seem, however, that these phobias have implications for the quality of these people's lives. Approximately 65% of these admissions were short term admissions for periods of respite. Thus the majority of these patients live in the community with their phobias.

It might be argued that although the patients had multiple phobias they did not necessarily lead to avoidance behaviour, for example, many patients travelled on buses. However, the individuals were still frightened of the object and have to live with their fear from day to day. Most of the patients with phobias of insects were aware of avoidance behaviour and this frequently interfered with their lives. For example, one relative describes her physically fit, mentally handicapped son going "berserk" if he hears the buzz of a large house fly. The family have to remove the fly as soon as possible to relieve their son's anxiety.

In recent years behavioural techniques have produced an effective therapy for phobic disorders. Commonly members of the public regard the mentally handicapped as being "odd" because of various behavioural mannerisms or disturbances. Thus the young mentally handicapped man who goes "berserk" when he hears a house fly in a restaurant, for example, will create a disturbance, cause his parents to be embarrassed and be labelled as "odd" by members of the public. The findings suggest that there may be large numbers of mentally handicapped people living in the community with phobias that could be successfully treated by behavioural techniques. This could help to improve the general quality of their lives. These findings represent the extent of psychiatric problems in consecutive adult admissions; behaviour and psychological problems in the under 16's might be larger.

Ballinger and Reid (1977) have reported that 10 out of 75 mentally handicapped adults (about 13%) who lived in the community and attended an adult training centre were rated as having significant psychiatric disorder. This study also indicated that 23 out of 75 inpatients (31%) had significant psychiatric disorder. The DHSS survey (1972) indicated that 16% of inpatients had severe behaviour difficulties, and 16% a lesser degree of behaviour disturbance. In this study, 16.5% of male admissions and 25% of female admissions, about 20.7% of total admissions, indicate the psychiatric business of an inpatient service for the mentally handicapped. Approximately 65% of these adult admissions were for short periods of respite. This raises the question as to the role of hospitals for the mentally handicapped in the future and underlines the case for integration of mentally handicapped and psychiatric services.

Table 1
Degree of Mental Handicap

<i>Degree MH</i>	<i>Male</i>	<i>Female</i>
Mild	12	3
Moderate	11	10
Severe	9	8
Profound	0	0
TOTAL	32	21

Table 2
Symptoms — Score 2 - 4

	<i>Male (N = 23)</i>	<i>Female (N = 16)</i>
1. Somatic symptoms.	3	5
2. Excess concern with bodily function.	1	0
3. Fatigue.	0	0
4. Sleep Disturbance.	2	4
5. Hypnotics.	0	3
6. Irritability.	5	4
7. Lack of concentration	0	0
8. Depression.	5	8
9. Depressive thoughts.	2	3
10. Anxiety.	4	3
11. Phobias.	11	12
12. Obsessions & Compulsions.	0	0
13. Depersonalisation/ Derealisation.	0	0

Table 3
Manifest Abnormalities Rating 2 - 4

	<i>Male (N = 32)</i>	<i>Female (N = 21)</i>
1. Slow.	4	2
2. Suspicious.	0	1
3. Histrionic.	0	0
4. Depressed.	6	8
5. Anxious/Agitated.	1	1
6. Elated.	0	0
7. Flattened/Incongruous.	1	2
8. Delusions/Thought Disorder.	0	0
9. Hallucinations.	0	1
10. Intellectual Impairment.	0	1
11. Overactivity.	1	0
12. Distractability.	5	2
13. Stereotypy.	0	0
14. Hostile Irritability.	0	0
15. Lability of Mood.	0	3
16. Pica.	0	0
17. Self-Injury.	0	0

Table 4
Breakdown of Phobias — Rating 2 - 4

	<i>Male (N = 11)</i>	<i>Female (N = 12)</i>
1. Being alone in house	0	1
2. Going out by yourself	4	7
3. Travelling on buses/trains	5	8
4. Animals	6	7
5. Insects	3	7
6. Heights	2	5
7. Dark	7	11
8. Others — thunder/lightning	4	7

Table 5

Overall Severity Rating

Rating	0	1	2	3	4	TOTAL
MALE	17	9	3	3	0	32
FEMALE	13	3	0	4	1	21

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