

Challenges in Identifying Mental Health Issues in Individuals with Severe Autism

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Abstract

Despite the growing realization that people with developmental disabilities are prone to mental health problems, clinicians continue to be challenged in recognizing psychiatric disorders in the presence of severe autism or mental retardation. This paper examines some of the difficulties encountered by clinicians that lead to either a failure to identify the presence of a psychiatric disorder or to a misdiagnosis of the underlying mental health problem. This phenomenon occurs most frequently as an individual's cognitive limitations become more severe. Understanding the impact of an individual's developmental level on the clinical features of a mental health problem is crucial for both diagnosis and intervention.

Challenges in Identifying Mental Health Issues in Individuals with Severe Autism

It has only been in the relatively recent past that we have come to acknowledge that people with autism can also suffer from mental health disorders. We know now that people with developmental disability, in general, experience similar kinds of mental health problems as their non-disabled peers. In fact, they are relatively more prone to emotional and psychiatric disorders than the general population. For example, children with Autistic Spectrum Disorder showed higher rates of mood and anxiety problems compared to a community sample of normally developing children (Kim, Szatmari, Bryson, Streiner & Wilson, 2000). Despite this understanding, we continue to have difficulties in accurately identifying the specific disorder, particularly as the severity of the cognitive impairment increases. We are prone primarily to two types of errors. First, we may fail to identify the presence of a mental health problem; and second, we risk making an incorrect diagnosis.

Several factors may contribute to these errors. First, failure to identify the presence of a mental health problem may be due to diagnostic overshadowing (Reiss, Levitan & Szysko, 1982). In other words, clinicians tend to ascribe psychiatric symptoms to the developmental disability itself. For example, self-injurious behaviour may, in some circumstances, represent the atypical presentation of an obsessive-compulsive disorder in an individual with severe autism. However, self-injurious behaviour is oftentimes seen as part of the symptomatology ascribed to Autistic Disorder, and therefore, it may not be examined any further.

Second, clinicians may miss a mental health diagnosis, or make an incorrect diagnosis, because of a tendency to become focussed on associated problems, which may obscure core features of a disorder. For example, individuals with severe autism who are also depressed, may be prone to aggression or tantrums. In some cases, the associated problem of aggression/tantrum becomes the sole focus of the assessment and subsequently, of treatment. However, when tantrums/aggression are in fact driven by an underlying agitated depression, efforts to treat only the aggressive behaviours are less likely to succeed.

Sometimes, it may become clear that a mental health problem exists, but the specific disorder may be difficult to identify and a misdiagnosis is made. Several factors are implicated in this increased level of difficulty in making a differential diagnosis in the case of people with Autistic Disorder. First, under stress, there is a greater likelihood for individuals with autism to decompensate acutely, a process that has been labelled as Cognitive Disintegration (Sovner & Hurley, 1986). These anxiety-based decompensations are sometimes misdiagnosed as psychotic. Yet, this decompensation is likely due to the fact that the individual has limited resources for coping and therefore regresses, and his/her behaviour may appear as "bizarre".

Limited social experiences can also affect the presentation of a mental health problem in individuals with severe autism. People with cognitive limitations tend to be much more concrete in their thinking and in their expressions, thereby giving the impression that they are delusional or they are hallucinating. It is not uncommon for developmentally delayed individuals to talk to themselves or to hear their own thoughts as a voice inside their head. These examples of developmentally normal behaviour must be distinguished from command hallucinations implied by a psychotic disorder (Levitas & Silka, 2001).

We must also be mindful of our reliance on informant reports, which is frequently problematic with people with autism. Oftentimes, and completely inadvertently, informants report higher rates of externalizing types of problems (e.g., conduct problems such as aggression) while underreporting symptoms such as sadness, disturbed sleep, poor appetite, and decreased concentration. Yet these symptoms, though diagnostically non-specific, may be good indicators of an underlying psychiatric disorder.

Surface manifestations of mental health disorders in severely autistic individuals may not be the same as those presented in our classification schemes, which are based on the manifestations shown by adults with an average IQ. Given that the phenomenology of a psychiatric disorder may be different in people with a developmental delay, clinicians may misdiagnose (or, as discussed above, fail to diagnose) a disorder if adult norms are applied to the assessment of individuals with significant developmental delays. The milder the disability, the more similarities exist between disabled and non-disabled adults. In the case of the individual with severe autism, however, the similarities with the normative classification scheme are even further reduced, and hence, add an additional layer of difficulty to making an accurate diagnosis.

A trend that has emerged in the literature is that the symptomatic presentation of numerous psychiatric disorders varies according to the degree of disability. Individuals who have only a mild developmental disability appear to present with the generally accepted criteria as they apply to the general population. In adults with severe or profound developmental disabilities, however, the symptoms are manifested by a more atypical presentation. This is elucidated in a study by Marston, Perry and Roy (1997), who compared three groups of depressed individuals of varying cognitive limitations. They found that two symptoms, depressed affect and sleep disturbance, were common to all participants, irrespective of the degree of disability. However, there were also distinct symptoms based on the degree of disability. For the more severely disabled individuals, the symptoms of depression included more behavioural disturbances such as aggression, irritability and self-injurious behaviour. Similar results were reported in 1995 by Meins. He found that individuals with mild disabilities were diagnosed successfully by using DSM criteria of depression, whereas those with severe disabilities presented with more atypical symptoms such as irritability, psychomotor agitation, increased behaviour problems, and less frequently, also loss of adaptive behaviour.

Although these symptoms lack diagnostic specificity, it is important to give them special consideration, in the case of people with developmental delays, as possible markers of psychiatric disturbance. Meins (1995) reported that in people with more severe developmental disabilities the severity of existing behaviour problems was higher in the presence of depression. Similarly in an earlier study, Reiss and Rojahn (1993) found that criterion levels of depression were evident in four times as many aggressive as non-aggressive individuals.

In an effort to understand how developmental level impacts on the clinical features of a mental health disorder, we rely on the study of Developmental Psychopathologies. Charlot (1998) summarized symptoms of depression in four developmental groups in order to demonstrate differences in the phenomenology of depression at different developmental levels. She demonstrated that individuals with a mild disability were

most similar to adolescents in the manifestation of their depressive symptoms. Adults with severe cognitive delays and depression, on the other hand, showed characteristics usually seen in young children. Charlot (1998) also summarized the presentation of various psychiatric disorders in children and their manifestation in adults with mental retardation. Once again, for all eight psychiatric disorders examined, striking resemblances were noted between the two groups.

The preceding section has alerted us to the possibility that challenging behaviours among people with severe developmental disorders are not necessarily maintained by behavioural processes but may, in fact, represent atypical (and therefore unrecognized) expressions of a psychiatric disorder. This, of course, is not meant to preclude the possibility of both factors operating, namely, that behavioural processes are involved within the context of an underlying psychiatric disorder. Emerson, Moss and Kiernan (1999) have postulated that challenging behaviours may pre-exist in the person's repertoire as functional and "adaptive" responses. The role of the psychiatric disorder is to provide the motivational basis within which these pre-existing challenging behaviours are likely to be evoked. For example, an individual with autism may have learned (operant) that (s)he can stop unwanted demands by becoming aggressive. Let's assume this individual is suffering from depression and therefore does not want to be engaged or taken on an outing. In order to avoid this, (s)he engages in aggressive behaviour, which has acted as a negative reinforcer in the past. In the example presented above, aggression is not evoked merely by the depression but rather by an interactive process of: (1) the depression establishing certain activities otherwise considered as pleasant (e.g., going on an outing) as noxious; and, (2) the individual using a pre-existing behaviour in his/her repertoire (i.e., aggression) that had been effective in the past in escaping unpleasant or unwanted events.

The implication for treatment within this latter conceptualization is that, although it is important to diagnose and treat the underlying psychiatric disorder, in addition, behavioural approaches should be incorporated to teach more socially acceptable behaviours of escaping the unpleasant event.

At this point, it is important to consider our reaction to specific behaviours in the two groups. One of the symptoms noted in children diagnosed with Generalized Anxiety Disorder, is need for reinforcement and approval. Adults with developmental delay or autism, who display excessive need for approval, may be described as excessively "attention-seeking". Yet this, along with restlessness, and decreased frustration tolerance may be part of an anxiety disorder. Unfortunately, these types of problems are most likely associated with a variety of maladaptive behaviours, which in turn may be viewed as learned problem behaviours, thereby missing the association with an Anxiety Disorder.

The nature of aggressive behaviour displayed by adults with severe developmental delay may actually be more like that exhibited by persons with a similar mental versus chronological age. Irritability or aggression may act as a final common pathway for a wide range of problems in children and adults with severe developmental disabilities, more than for adults without developmental delay. For example, a normally developing toddler as well as an individual with severe autism may try to escape an unwanted demand by aggression. Similarly, an autistic individual may engage in self-injurious behaviour in response to a headache, anxiety, depression, or even over-stimulation. Likewise, a toddler may engage in tantrumous behaviour if frustrated, tired, or simply in reaction to stress for which he/she doesn't have any other options.

References

- Charlot, L. R. (1998). Developmental effects on mental health disorders in persons with developmental disabilities. *Mental Health Aspects of Developmental Disabilities, 1*, 29-38.
- Emerson, E., Moss, S., & Kiernan, C. (1998). The relationship between challenging behaviour and psychiatric disorder in people with severe developmental disabilities. In N. Bouras (Ed.), *Psychiatric and behavioural disorders in developmental disabilities and mental retardation*. Cambridge: Cambridge University Press.
- Kim, J. A., Szatmari, P., Bryson, S. E., Streiner, D. L., & Wilson, F. J. (2000). The prevalence of anxiety and mood problems among children with autism and Asperger syndrome. *Autism, 4*, 117-132.
- Levitas, A. S., & Silka, V. R. (2001). Mental health clinical assessment of persons with mental retardation and developmental disabilities: History. *Mental Health Aspects of Developmental Disabilities, 4*, 31-42.
- Marston, G. J., Perry, D. W., & Roy, A. (1997). Manifestations of depression in people with intellectual disability. *Journal of Intellectual Disability Research, 41*, 476-480.
- Meins, W. (1995). Symptoms of major depression in mentally retarded adults. *Journal of Intellectual Disability Research, 39*, 41-45.
- Reiss, S., Levitan, G. W., & Szysko, J. (1982). Emotional disturbance and mental retardation: Diagnostic overshadowing. *American Journal of Mental Deficiencies, 86*, 567-574.
- Reiss, S., & Rojahn, J. (1993). Joint occurrence of depression and aggression in children and adults with mental retardation. *Journal of Intellectual Disability Research, 37*, 287-294.
- Sovner, R. & Hurley, A. D. (1986). Four factors affecting the diagnosis of psychiatric disorders in mentally retarded persons. *Psychiatric Aspects of Mental Retardation Reviews, 5*, 45-49.