Review article

UDC: 616.895-008.458-07-08
doi:10.5633/amm.2011.0315

DIAGNOSIS AND TREATMENT OF DEPRESSION IN PERSONS WITH INTELLECTUAL DISABILITY

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This paper considers, from the theoretical point of view, the problem of diagnosing and treatment of depressive disorders in people with intellectual disability (ID), relying primarily on the results of previous researches, which stress the etiological, symptomatic, diagnostic and therapeutic specifics when it comes to depression and its correlates in this population. The interest in mental health and psychopathology of people with ID intensified during the seventh decade of the previous century, when it became clear that some cognitive and behavioral symptoms are not, as hitherto thought, only a part or a consequence of the syndrome of intellectual disability, but a sign of ongoing mental disorder. So, the idea of ''dual diagnosis'' was born, and now it provides guidelines for the growing number of studies which theoretically and empirically review different issues of mental health problems in people with ID. Likewise, the observation of syndrome groups of genetic disorders resulting in intellectual disability has led to the narrowing of the circle of genetic syndromes that carry increased risk for the onset of depression and its correlates, such as: Down syndrome, Fragile X syndrome and Prader-Willi syndrome. Potential diagnostic problem in people with ID, when it comes to depression, may arise from ''diagnostic overshadowing'' of depression symptoms, which often remain hidden under abnormal behavior and adjustment disorders, especially in patients with severe forms of ID. As a possible way to overcome these problems some authors have proposed the concept of ''behavioral equivalents of depression'' or behavioral disorders that evidently can be associated with depression, such as social withdrawal, aggression, hostility, irritability, psychomotor agitation or retardation. Intensification of these forms of behavior may be a sign of developing depression, and in that sense, this view represents a useful starting point. When it comes to therapeutic approaches, there is a general tendency in favour of psycho pharmacotherapy in the treatment of depression, although there is a growing number of researches that prove the favourable effects of cognitive-behavioral and psychoanalytic psychotherapy. *Acta Medica Medianae 2011;50(3):81-89.*

Key words: *intellectual disability, depression, diagnosis of depression, treatment of depression*

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Introduction

New researches in field of mental health and mental illness have shown an increasing trend in the number of patients suffering from various forms of depressive disorders. Depression is becoming the leading disease of modern times, and with the anxiety disorder it is one of the leading causes for seeking help from psychiatric services (1). Ranging from mild manifestation of depressive symptoms to clinically diagnosed disorder, depression lies deeply in the sphere of emotional, cognitive, motivational and somatic functioning of an individual. Depression involves a complex pattern of deviant emotions, cognition and behavior, a cluster of symptoms that can vary in prominence from mild to very severe (2).

In the recent years, researches dealing with depressive disorders in persons with intellectual disability (ID) have become particularly interesting due to the fact that epidemiological studies have shown significantly higher incidence of depression in this population (3). By definition of the American Association of mental retardation (AAMR) from 2002, intellectual disability is referred to as "... substantial limitations in present functioning and is characterized by significantly subaverage general intellectual functioning existing concurrently with related limitations in two or more adaptive skills areas as expressed in conceptual, social and practical adaptive skills. This disability manifests before the age of eighteen." This definition is based on several assumptions, which are primarily related to the appreciation of lags in the different spheres of adaptive skills, not just intellectual. Similarly, the diagnosis of intellectual disability, according to this approach, must also respect

cultural, communicative, linguistic and behavioral differences, and represent a starting point to determine individual strengths and weaknesses in the spheres of intellectual, adaptive and emotional state, physical health and social conditions, which will determine the planned intensity and quality of the necessary support (4): intermittent, limited, extensive or pervasive.

Intellectual functioning is expressed in intelligence quotient (IQ), which is assessed through psychometric tests. In 1977, AAMR provided a scheme for classification of intellectual disability levels. This scheme is based on the measured IQ levels that can reveal the following degrees of ID: borderline (IQ 67-83), mild mental retardation (IQ 50-66), moderate mental retardation (IQ 33-49), severe mental retardation (IQ 16-32) and profound mental retardation (IQ<16) (5), and it is still being used in the DSM-IV classification system.

In the international classification of diseases (ICD-10), intellectual disability is defined as the state of stopped or incomplete mental development, which is particularly characterized by cognitive dysfunction, speech, motor and social skills problems, the evaluation of which is required to set up a final diagnosis. There are four levels of ID: F70 mild (IQ 50-69), F71 moderate (IQ 35-49), F72 severe (IQ 20-34) and F73 profound (IQ<20). Classification group F78 (other ID) is used in the presence of sensory or other associated damages, when it is difficult or impossible to determine the degree of ID, and F79 (unspecified mental retardation) is used when there are some indicators, but not enough information to set up a final diagnosis (6).

Data on prevalence of ID indicates that it is present in about 2%-3% of general population. About 70% of the cases fall under mild ID (organic causes unknown), and 30% fall under other levels (for the majority of cases, the organic substrate is known). The prevalence is slightly higher in boys, which is explained by hereditary factors, such as X-linked intellectual disability (7).

Intellectual disability is a neurodevelopmental disorder associated with various etiological factors such as biological, psychosocial and combined. Also, distinction can be made with regard to the time of the ID onset: prenatal (genetic factors, CNS malformations, metabolic diseases of mothers etc.), perinatal (birth complications, infections...) and postnatal (infections, intoxications, trauma, and psychosocial deprivation). A distinct organic disorder that could be considered responsible for problems in intellectual development cannot be identified in more than 70% of cases at the current state of scientific knowledge (4,7). ID is often accompanied by epilepsy, some authors state that the prevalence of epilepsy among persons with ID ranges from 20-30% and emphasize that the frequency and severity of epileptic seizures are conditioned to a greater extent by primary cause of ID than by its degree (4,7).

Complex syndrome of intellectual disability involves specific psychosocial characteristics that are present in disabled persons and modelled by insufficiently integrated functions of the central nervous system, poor differentiation of gnostic functions and accompanying poverty of emotional and social development. Delayed development of verbal skills and difficulties in learning, memorising, emotional maturation and development of self-concept lead to inability to understand and meet the demands of reality and consequently to low self-esteem and cognitive distortions that change the self-image, which creates favourable conditions for manifestation of psychopathological phenomena.

Epidemiology

The interest of researchers in problems of diagnosis and treatment of psychopathological manifestation in persons with ID is of a recent date (9). The reason for this was the fact that mood disorders and different forms of deviant behavior and thought were viewed as a consequence or integral elements and symptoms of ID itself until 1970s. These disorders were often ignored or suppressed by taking restrictive educational and corrective measures or applying psychopharmacs (tranquilizers and antipsychotics), without making the effort to establish accurate diagnosis. Pioneering work in this field started during the 1970s, at first with patients with mild ID, who could be subjected to the conventional diagnostic procedures since their communicative skills were preserved (4).

According to some authors, and based on epidemiological studies, in as many as 30-60% of persons with ID a mental disorder can be identified as well, depression is the most frequent one, side by side with schizophrenic psychosis, attention deficit hyperactivity disorder and personality and impulse control disorders (10). Data on the prevalence of depressive disorders when compared to other forms of psychopathology in persons with ID shows the prevalence ranging from 44% to 57% (11, 12). Frequency of depression in people with ID is twice as high as in the general population. Depression occurs in one of ten persons with ID. Symptoms of major depression are present in about 5% of them. Studies of gender differences had shown greater frequency of depressive disorders in mentally disabled females, but there were also some recent studies that did not record statistically significant differences in this respect (13). Depressive symptoms tend to occur more frequently in elderly and also tend to become more severe with increasing age. On the basis of the above mentioned facts, it is clear that there is an agreement among different authors about the existence of enhanced vulnerability of persons with ID to develop symptoms of depression, significantly higher than among persons without ID. The special attention has been paid to this problem for about 20 years, since it has been recognized that adequate diagnosis and treatment of depressive disorders in this population is of great importance, mainly because of the serious impact that depression has on the life quality of persons with ID and their overall level of functioning and social adaptation.

Diagnostic problems

One of the ultimate problems regarding the issue of depressive disorders in persons with ID is the question of the diagnosis itself. The question is to what extent the existing standard diagnostic procedures and techniques are applicable to patients with ID. The main problem lies in the fact that most of the existing diagnostic instruments are based on self-assessment of symptoms by the patients themselves through the appropriate item scale. Self-assessment, above all, implicitly includes a certain degree of person's understanding of his/her own psychological states, as well as the willingness to communicate them to others. In that sense, the application of existing diagnostic tools in patients with ID can be a source of problems arising as a consequence of cognitive, verbal, social and adaptive deficits, which are the substance of intellectual disability syndrome. The potential solution to this problem, as many authors suggest, is to make sure that the person understands all of the items before the scale is used, but also, it is recommended that the understanding itself should be substantiated by application of visual aids and by mentioning of particular events and situations that create spatial-temporal framework in which person should consider his/her own emotional and behavioral states. It is also suggested to avoid the questions requiring from person to assess the way the other people see and understand him/her, because this kind of insight requires a high level of social understanding, which is not found in people with limited social-cognitive capacities (14). Furthermore, most researchers claim that parents, guardians, teachers or caregivers tend to underestimate or overlook depressive symptoms in persons with ID, while the results obtained through self-assessment include to a greater extent symptoms such as fatigue, boredom and indifference to the world around them, low self-esteem and feelings of guilt (15).

Behavioral equivalents of depression

Diagnosis of depression in persons with ID, particularly in those with more severe degree of disability, often or always relies on assessments of parents, guardians or staff who works with them. This approach implies, first of all, that those outside observers are able to recognize signs of depression and psychiatric symptoms that differ from problems in adaptive behavior. Confusion in this area leads to so-called ''diagnostic overshadowing'' of the symptoms of depression, which remain hidden by abnormal behavior or symptoms atypical for depression (16,17). The presence of depressive symptoms is more easily recorded in persons with mild degree of ID, because they have relatively preserved cognitive and communicative capacities that allow them accurate introspection and communication about internal emotional states, mood, thoughts and psychological distress. On the other hand, in cases of people with severe degree of disability, diagnosis of depression may represent a serious challenge, primarily because of communication barriers, symptoms of brain damage, and a number of obvious behavioral disorders, such as rage attacks, auto and hetero aggression, social withdrawal and stereotype and repetitive behavior, which can mask the present depression. As a potential solution to these diagnostic concerns, some authors have suggested the concept of "behavioral equivalents of depression", i.e. evident behavior disorders that are associated with depression (17). It was presumed that the externalized symptoms manifested through inadaptive behavior and numerous forms of vegetative symptoms would gradually come to dominate the entire spectrum of intellectual disability, especially when there is more severe degree of impairment, in comparison with cognitive and motivational, hence internalized symptoms, which can accurately be detected only in mildly, partially and moderately intellectually disabled persons. Such thoughts are a logical consequence of knowing the very essence of intellectual disability syndrome, which is in more severe cases, characterized by almost complete lack of conceptualization, and therefore by the inability to elaborate the relations between I and the external environment, and by the lack of motivation that can rise above the mere physiological existence. After these theoretical assumptions were given, some empirical studies were conducted and they proved that some inadaptive and problematic behaviours are, actually, significantly more frequent in people with severe levels of ID and comorbid depression, such as the attacks of hetero- and auto-aggression, temper tantrums, screaming, crying, psychomotor agitation, irritability, social isolation, etc. (18, 19). Conclusion was that the intensification of these behavioral patterns can be associated with depression and can even become a diagnostic guide especially in cases of severe and profound intellectual disability. According to these findings, when diagnosing depressive disorders, through the entire spectrum of intellectual disability, it is desirable to combine the standard diagnostic criteria with the observation of behavior and the inclusion of behavioral criteria in the process of diagnosis (17, 20).

Diagnostic instruments

The issue of diagnostic instruments for depression that are suitable for population of intellectually disabled people still remains open, primarily because of ambiguous evidence concerning validity and reliability of standard instruments designed to diagnose depression in people of average population when applied to population of intellectually disabled people. There was a number of attempts to modify existing instruments, in order to customize them for cognitive, communicative, social, and symptomatic peculiarities of this population, as well as to create completely new instruments, designed primarily for people that function on deeper levels of disability. Today, many researchers claim that the following scales

are most widely used for diagnosing depression in people with ID: BDI-II (Beck's Depression Inventory), SRDQ (Self Report Depression Questionnaire), RADS (Reynolds Adolescent Depression Scale, suitable for use in adults with ID: Reynolds, 1987), PIMRA (Psychopathology Instrument for Mentally Retarded Adults - the instrument for assessing psychopathology in people with ID: Matson 1988), DBC-A (Developmental Behavior Checklist for Adults) (21), and DASH-II (Diagnostic Assessment Schedule for Severely Handicapped - Inventory of diagnostic assessment of severely retarded: Matson et al. 1991), RSMB (Reiss Screen for Maladaptive Behavior: Reiss, 1988) and PAS-ADD.

The problem with applying diagnostic instruments developed for people without disability lies in their reliability. Therefore, there are attempts to design adapted classification systems and diagnostic guides to be applied in persons with ID. National Association for Dual Diagnosis (NADD), in association with American Psychiatric Association developed a classification system that is an adaptation of DSM-IV classification system, which provides more accurate diagnosis of mental illness in persons with ID, taking into account the etiology and degree of intellectual disability, as well as standard DSM-IV categories (Diagnostic Manual-Intellectual Disability, DM-ID). The main advantage of this diagnostic method is the fact that it takes into account pathoplastic effect that intellectual disability may have on the structure and ways of manifestation of psychopathological phenomena. This is especially applicable to disorders from depressive spectrum, having in mind their high frequency in this population, as well as the atypical manifestations and available therapeutic solutions. One of the significant specifics concerns, for example, replacement of traditional diagnostic criteria for depression, ''depressed mood'' with relatively atypical ''irritable mood'', which proved to be much more frequent and more accurately reflects current depressive disorder in persons with ID.

Etiological factors

Study of etiological factors that are important for manifestation of depression relies on different theoretical and methodological approaches, ranging from the studies of hereditary factors (the study of family trees, twin studies), through emphasizing certain biochemical aspects (metabolic disorder of electrolytes, changes in monoamine neurotransmission), to the psychoanalytic interpretation (ambivalence, oral fixation, complications of object relations, «hunger» for external gratification, deprivation, regression) and dominance of theories of learning (negative reinforcement, learned helplessness ...). When it comes to people with ID, the mechanisms that lay behind the onset of depressive symptoms are not fully resolved, but some authors as possible causal factors mention changes on neurochemical and neurobiological level that are followed by certain organic brain damages, which cause specific vulnerability of certain neurotransmission systems, traumas or genetically determined diseases, basic psycho-biological affective reactions associated with the environment and the negative impact of the environment, affective deprivation etc. Sudden changes in the existing affective relationships and chronic feelings of rejection and misunderstanding may also be of particular importance.

Syndrome analysis

Current trend in studying the phenomenon of intellectual disability is the so-called syndrome analysis, which is based on genetic-constitutional specifics of certain syndromes that, in addition to variable symptoms, also cause a decline in cognitive capacity. Dealing with the psychopathology in persons with ID, syndrome analysis offered an overview of the clusters of psychopathology that are specific for certain genetic disorders and syndromes. Several researches have led to the conclusion that the presence of some genetically determined disease carries with itself an increased risk for depression development, and a typical example of that is the Down syndrome. Some authors emphasize that people suffering from Down syndrome are particularly susceptible, and that depression is considerably more frequent in these people than in any other etiological group of intellectually disabled. It was, to some extent, a surprising discovery, considering the fact that people with Down syndrome are generally less susceptible to psychopathology compared with other groups of mentally disabled, especially when compared with persons suffering from autistic spectrum disorders. It is interesting to mention that the degree of depression in people with Down syndrome increases with age. Adolescents and adults with Down syndrome show a greater degree of social withdrawal, psychomotor retardation and inhibition than children with Down syndrome. Even though depression is manifested by irritability, hyperactivity, stereotypic and self-harm behavior in the early years of life, with increasing age there is a tendency of internalization of symptoms where social withdrawal, isolation, and overall avoidance of social contacts becomes predominant. Such developmental course of clinical features of depression was not observed in other etiological groups of people with ID (23). It is also significant to note that signs of depression in people with Down syndrome may sometimes represent a pretrial symptom of dementia (24), especially when they are manifested through intense vegetative disturbances, irritability, lack of cooperation, depressed mood, anxiety and often auditory hallucinations. Some authors also claim that these people have one characteristic in common - low serotonin levels, which may explain the vulnerability and susceptibility to depressive disorders.

Serotonergic hypothesis of etiology of depression has led to new approaches in the study of psychopathological phenomena in persons with autism. Namely, it is known that autism is characterized by increased blood and paradoxically reduced brain serotonin, which served as the

starting assumption in attempts to treat aversive behaviors in autistic persons with serotonin re-uptake inhibitors, common as the drug of choice in treating depressive disorders (25). This primarily refers to perseverative and repetitive behavior, irritability, temper tantrums and different forms and levels of aggression in autistics (26). These disturbances and aversive behaviors are typical symptoms of autistic spectrum disorders, and it is often very difficult to determine whether they are behavioral equivalents of depression or classic symptoms of autism. Autism is characterized by a marked rigid behavior and thinking, impaired communication, socialization and imagination, or disposition to cling to routines in everyday functioning, which represents a significant barrier to social adaptation. Persons with autism are under increased risk of developing depression because of the constant distress in contact with an environment in which every event, especially the unexpected change in situations or relations can be considered dangerous and threatening. Having the above mentioned findings in mind, when diagnosing depressive disorder in persons with various etiologies of ID it is necessary to respect the development principle, which takes into account the individual development level of each person with ID, that is determined by a whole range of genetic, neurobiological, environmental, personal and many other factors.

Social causes of disorder

Although people with intellectual disability are a very heterogeneous group in terms of etiology and degree of disability, we can say that there are certain common characteristics that make them vulnerable when it comes to depression. Some of the most important, such as poverty of social contacts and deprivation of social participation, lack of social support and proportionally large number of adverse life events should be mentioned (12). For example, it is reported that frequent exposure to unpleasant experiences and deficits in social relationships are related to depression. Many studies involving human subjects with mild ID emphasize the link between social skills deficits and problematic behavior with depressive symptoms. In the absence of positive social reinforcement, people with cognitive deficits exhibit adaptive and social skills disorders, which can lead to further deterioration of interpersonal relationships and the manifestation of depression. People with ID are generally exposed to a reduced number of events and contacts, and most of the interpersonal relationships are experienced as a conflict (28). There are also findings that indicate that higher frequency of life events and social contacts and greater exposure to different social situations carry greater risk of depressive reactions, which confirms that these people have great need for well-known conditions and situations, that they are poorly adaptable, cognitively inflexible and resistant to change (29). Other causal environmental factors important for the developing of depression in people with ID include the following that should also be taken into consideration: poor socio-economic status, incomplete families, living with only one parent, residing in the institutions of the restrictive type, frequent changes of residence etc.

Depression from perspective of cognitive theory

Cognitive theory of depression postulates that there is increased susceptibility to depression in people with maladaptive cognitive styles that trigger the manifestation of depressive disorders as reactions to stressful life events. This T. Beck's (1967) theory emphasizes the significance of early stressful experiences in modelling of negative expectations and negative self-schema (30). Later in life, stressful life events reactivate the self-schemas and influence the production of negative automatic thoughts about self, environment and future (Beck's cognitive triad). Some researches have shown that there is a connection between negative social comparisons and depressive symptomatology in persons with ID. Also, depression in people with ID is associated with poor self-concept and low self-esteem. This type of assessment is in connection with person's awareness of his/her own limitations and differences, that comes as a consequence of failure in certain socially valued activities. Damaged cognitive ability, difficulty in solving problems and inflexibility in dealing with changes in the environment are significant risk factors for developing depression, especially in people with mild ID (31). Researches show that cognitive triad can be detected in depressed persons with ID at levels of mild and moderate ID, who show signs of negative thoughts about themselves, feelings of hopelessness and low self-esteem, which can be correlated with the cognitive triad. Some of these aspects, if present in persons with ID who are not diagnosed with depression, may be important predictive factors for its occurrence later on, and those are, as mentioned above, poor self-esteem, negative thoughts about themselves, life and future and low self-evaluation as a result of comparison with others (32).

Symptoms characteristics

The main characteristic of depressive symptoms in persons with ID is that they are atypical, diverse and often unrecognizable under the facade of problematic behavior and adjustment disorders (33). While researching the depressive symptoms, most authors dealing with the study of intellectual disability observed general tendency of symptom externalization, domination of irritability and high presence of deviant behavior, which at first glance do not have much in common with the classic symptoms of depression in the general population (34). In presence of mild, partial, or moderate degrees of intellectual disability, standard (common) depressive symptoms such as: depressed mood, anhedonia, psychomotor retardation or agitation,

daily fluctuations of mood, a number of vegetative symptoms (sleep disturbances, somatic complaints, eating disorders with weight loss or gain, etc.) may be observed, and this allows the application of generally accepted diagnostic criteria. Here we should also mention the presence of cognitive distortions in patients with mild ID, who usually have relatively preserved cognitive capacities and certain ability to conceptualize their own difficulties, so in those cases feelings of sadness, hopelessness, low self-esteem, guilt, as well as fear of loss, the actual or symbolic abandonment, suicidal ideas and attempts are also reported. With the deepening of intellectual and adaptive retardation, typical feeling of sadness turns to diffuse feelings of weakness and unspecified illness (8); the number of somatic complaints and vegetative symptoms grow and irritability starts to dominate the clinical picture. Weakening of social contacts is also present, with withdrawal from the social activities, eye-contact reduction, prolonged speech latency, neglect of personal appearance and hygiene, and even self-harm and hostile behavior, which could all be noted as "behavioral equivalents of depression" (17, 34).

The greatest diagnostic challenge is, after all, detection of depressive symptoms in severely and profoundly intellectually disabled persons. Some researchers note that these persons are at higher risk of developing depression than people with mild ID. Nevertheless, depression among them is often very hard to recognize because of the ''diagnostic overshadowing'' which stands for attribution of depressive symptoms to ID itself (16, 20). A particular problem in diagnosing, aside from significantly atypical symptoms, can be severe disorders of verbal communication and lack of subjects' ability to evaluate their own psychological states and problems, so diagnosis must be made according to objective, outside observation of typical behavioral changes and maladaptive behavior, which are basically just a manifestation of the underlying depressive disorder (20). Depression is often associated with the expression of aggressive behavior, autoaggressive and suicidal behavior. Often, in people with severe and profound ID temper tantrums, extreme self-isolation, screaming, crying, stereotyped behavior, constipation, sleep and appetite disturbances and significant irritability are found. Such manifestations are very difficult to systematize and to prove that they actually originate from depression, primarily because they often occur in these people regardless of the depression. So, it is essential to correlate the occurrence of such forms of maladaptive behavior with the onset of depression, which is additionally complicated by the fact that, under the influence of depression, certain environmental events are perceived as extremely unpleasant and threatening, for example the insisting of the environment that the person should participate in some activities for which he/she has lost interest after the occurrence of depression can lead to extreme irritability and subsequent self-harm (33).

Therapeutic approaches

The dominant therapeutic approach in treating depression and other forms of psychopathology in persons with ID is the application of psychotropic medications in combination with different methods of behavioral modification. Predominance of psycho-pharmacology results from a natural expansion of newly acquired knowledge concerning the biochemical and molecular background of mental illness, and long-standing attribution of mental problems in persons with ID to the characteristics of intellectual disability itself. Penetrating into the very essence of intellectual disability issues made it clear that in people with ID, especially in cases with mild and moderate disability, all standard therapeutic methods used for treating mood disorders in people without disability can be successfully applied, including those methods that were considered inapplicable due to the limited conceptualization and verbalization in the intellectually disabled, such as various forms of psychotherapy (35), cognitive and emotional training, creative therapy and many others. Of course, they have to be appropriate for the developmental level, the degree of intellectual disability, and verbal capabilities of respective person. The only successful way to treat depressive disorders in person with ID is integrative therapy, which involves the participation of an entire team of experts - a psychologist, psychiatrist, social worker, special education teachers, whose goal is primarily to diagnose disorders, and then to accordingly perform specific therapeutic procedures (36).

Another problem with applying psychotropic drugs for treatment of depressive persons with ID is their increased tendency to cause adverse events and side effects. A large number of mentally disabled, especially those with deeper levels of disability, suffers from epilepsy, which brings to attention the problem of interaction between anti-epileptic therapy and other psychotropic drugs applied. The matter is further complicated by serious health problems commonly present, such as heart disease, hypo-thyroidism, liver and kidney diseases, etc. Because of the severe intellectual deficit, the impossibility to conceptualise their problems and impaired verbalization, people with ID frequently cannot communicate problems and adverse effects of drugs, which may also represent an obstacle, since these side effects can occur and be detectable only through maladaptive behavioral forms, such as agitation, aggression or suicidal behavior, which additionally complicates the diagnosing of psychopathological disorders, as these events may incorrectly be recognised as psychosis or depression.

Depressive disorders in people with ID are, as stated, atypical, chronic and often highly variable in expression. Many cases of persistent depressive disorders, especially in severely disabled, are, in fact, rapid cycling bipolar disorders, that may give good response to psychostabilizers (24), in combination with antipsychotics or antidepressants. The use of

new antidepressants such as selective serotonin reuptake inhibitors - SSRI (fluoxetine, sertraline, paroxetine ...) and combined serotonin-norepinephrine reuptake inhibitors - SNRI, which significantly improve the symptoms of depression, and have positive effects on reduction of aggression and self-harm behavior in severely disabled and autistic persons, is also justified. It is reported that tricyclic antidepressants and SSRIs are rarely used simultaneously for the treatment of depression in people with ID, due to the lack of experience concerning the possible interactions and occurrence of adverse effects (37), which are difficult to detect due to inability of subjects to inform physicians, guardians or members of the family about them. Researches on the role of cognitive factors in the etiology of depression in people with ID showed that frequency of negative automatic thoughts, feelings of helplessness, and low self-esteem significantly correlates with manifestation of depression in persons with mild and moderate ID, and it led to the conclusion that this population of depressive patients could also benefit from cognitive-behavioral therapeutic procedures (CBT) (11). In the past, it was accepted that therapy programs focusing on cognition can not have positive therapeutic effects on persons with ID, but some studies have proven the positive effect of CBT programs on depression and withdrawal symptoms in patients with ID (38). CBT intervention program usually involves encouraging individuals to participate in different social situations that provide development of social skills through role-playing and various forms of problem solving, that can be later applied to real life situations. In the program, participants are trained how to monitor their own thoughts and feelings, and to support positive, adaptive behavior. The emphasis is on the reshaping of the existing cognitive distortions and developing positive interpretations of life events by use of techniques such as behavioral modification, role-playing and structured feedback. Each group session gives participants opportunities through a variety of situations to develop skills that will enable them to improve quality of their lives and achieve better understanding of their own state (11).

Conclusion

There are numerous difficulties accompanying the study of depressive disorders in persons with ID. Many researchers reluctantly abandon the assumptions that these people cannot, due to their cognitive limitations, experience emotional, motivational and social devastation that depression brings with itself. The fact is that intellectual disability often leads to social stigma accompanied by a marked imbalance of social relationships, rejection and socio-emotional deprivation, which models the psyche of disabled persons making them susceptible to negative effects. Genetic specifics and intellectual or adaptive dispositions that these people are entering the world with model and change forms and quality of their early affective relationships, leaving indelible marks on the structure and sub-sequent functioning in «threatening and frustrating» world. Thus, the mental problems of these people, especially the tendency for depressive reactions and manifestation of clinical forms of depression, have roots in the very beginning of their social life, in the primary forms of social relationships within the family circle, but also in the relationships within first peer and social groups. Having a handicapped child to raise is a great challenge for each family, particularly those with reduced coping capacity and poor patterns of family relationships. Often, parents themselves become depressed as a response to demolition of the myth of a perfect child who would fulfil all their dreams. In that sense, a study of depression in mothers of disabled children and its effects on the latter psychological and physical development of a child could be very instructive. Child's disability is often an obstacle to the realization of safe emotional connections between mother and child, resulting in pathological patterns of rejection or overprotection of the child, who is thus denied the possibility to develop psycho-ogical apparatus for successful adaptation within the given genetic dispositions. The presence of mother's rejection, aversive stimuli and negative reactions, that cannot be predicted, understood or controlled creates conditions for the development and consolidation of learned helplessness, which is, in combination with social stigma, the existing genetic etiology, and neurological deficits, a suitable ground for structuring depressive reactions later in life. Learned helplessness in this regard can serve as a useful theoretical framework for studying depression in children and adults with different forms and levels of intellectual disability, primarily because it provides acceptable explanation for the specific behavioral cluster that commonly accompanies behavior of these people and implies the absence of initiatives in social situations, a characteristic avoidance of contacts and relationships, intensification of fear and anxiety when unknown stimuli are present, discouragement in dealing with problematic situations and finally the clinically recognizable manifestation of depressive symptoms. The importance of early depression diagnosis in persons with ID becomes clearer after the expansion of empirical researches that confirmed there is a danger of non-recognition of symptoms due to their tendency to be covered by behavioral problems and adjustment difficulties. Early diagnosing is mandatory for the timely initialization of the treatment, and also, there is a growing number of therapeutic procedures that can be adapted for the special requirements of disabled people. Review of etiological factors that underlie disturbed intellectual development lead us to the conclusion that there are two qualitatively different spheres of disability: borderline and mild disability ID on the one hand, with the dominance of socio-educational factors and deeper forms of disability (moderate, severe, profound) with apparent neuropathology and genetic etiology. In this sense, the study of depression should be placed in the etiological framework, taking into account the potential neuropathology which becomes dominant with the deepening of retardation and thus may be crucial for modelling of depressive symptoms (syndrome analysis).

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DIJAGNOZA I TRETMAN DEPRESIJE KOD OSOBA SA INTELEKTUALNOM OMETENOŠĆU

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Rad sa teorijskog aspekta razmatra problem dijagnostikovanja i terapije depresivnih poremećaja kod osoba sa zaostajanjem u intelektualnom razvoju oslanjajući se, pre svega, na rezultate dosadašnjih istraživanja, u kojima se naglašavaju etiološke, simptomske (patoplastične), dijagnostičke i terapijske specifičnosti kada su u pitanju depresija i njeni korelati kod ove populacije. Tek 70-tih godina prošlog veka postaje jasno da neki kognitivni i bihejvioralni simptomi nisu, kao što se do tada mislilo, deo i posledica sindroma intelektualne ometenosti, već znak postojećeg mentalnog poremećaja, što se označava terminom „dvojna dijagnoza". Posmatranje sindromskih skupina genetskih poremećaja koji kao posledicu imaju ometenost u intelektualnom razvoju dovelo je do svojevrsnog sužavanja kruga genetskih sindroma koji nose povećan rizik oboljevanja od depresije i njenih korelata, kao što su npr. Daunov sindrom, Fragilno X sindrom i Prader-Vili sindrom. Potencijalan dijagnostički problem kod osoba sa intelektualnom ometenošću, a kada je u pitanju depresija, mogu predstavljati tendencije "dijagnostičke zamagljenosti" simptoma depresije, koji često ostaju prikriveni abnormalnim ponašanjem i poremećajima prilagođavanja, posebno kod osoba sa težim oblicima intelektualne ometenosti. Kao mogući način prevazilaženja tih problema neki autori su predložili koncept ''bihejvioralnih ekvivalenata depresije'' ili u ponašanju evidentnih poremećaja koji se mogu dovesti u vezu sa depresijom, kao što su: socijalno povlačenje, agresivnost, hostilnost, iritabilnost i psihomotorna agitacija. Intenziviranje ovih obrazaca u ponašanju može biti znak razvijanja depresije, pa u tom smislu ovo gledište predstavlja korisnu polaznu tačku. Kada su u pitanju terapijski pristupi, postoji opšta tendencija potenciranja psihofarmakoterapije depresije, iako ima sve više istraživanja koja dokazuju povoljne efekte kognitivno-bihejvioralne i pshoanalitičke psihoterapije. *Acta Medica Medianae 2011;50(3):81-89.*

***Ključne reči**: intelektualna ometenost, depresija, dijagnostikovanje depresije, terapija depresije*