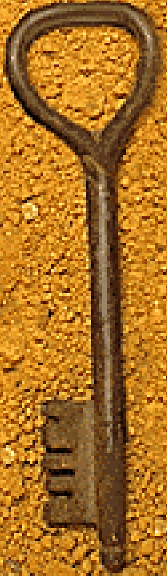
Unlocking and Treating Depression in Adults with Intellectual Disabilities

Molly Faulkner, PhD, CNP, LISW

CoC DDMI Coordinator

Clinical Director of NM Behavioral Health Workforce Initiative

UNM SOM Department of Psychiatry and Behavioral Sciences



Objectives

- **For the population of individuals with ID:**
  - List the **prevalence** of depression
  - Identify the **possible symptoms** of depression
  - Outline basic **assessment** for depression
  - Recognize **evidence based psychotherapeutic treatments** for depression
  - State **evidence based pharmacological medications** for depression

General Population Depression:

- Facts
- Illness on a Spectrum
- Risk Factors
- Diagnosis
- Extent of problem in adults, adolescents and children

- By 2020 the leading cause of disability and second leading contributor to global disease
- 10 to 20% of mothers after childbirth have depression
- Patient's culture, gender, and/or predominance of somatic symptoms can impede the detection of depression
- Up to 70% seen by PCP and up to 50% are misdiagnosed

Transient Sadness/Grieving

Adjustment Disorder

Dysthymia

Major Depressive Disorder

Bipolar Illness

Clinical Depression

- Spectrum Disorder
  - Subsyndromal (dysthymia) to syndromal symptoms (MDD)
- Syndromal disorder (MDD)
  - At least 2 weeks of persistent change in mood manifested by either depressed or irritable mood and/or
  - Loss of interest and pleasure plus a
  - Wishing to be dead,
  - Suicidal ideation or attempts
  - Increased/decreased appetite, weight, or sleep
  - Decreased activity, concentration, energy, or self-worth
- Change from previous functioning that produces impairment in relationships or in performance of activities.

Risk Factors for Depression

- ✓ Prior episode or episodes of depression
- ✓ Prior suicide attempts
- ✓ Being in the postpartum period
- ✓ Medical co morbidity
- ✓ Lack of social support
- ✓ Stressful life events
- ✓ History of sexual abuse
- ✓ Current substance abuse
- ✓ Woman (2x as likely to be depressed as men)

Diagnostic Criteria for Major Depression

Depressed mood or markedly decreased pleasure in most activities that occurs for 2 weeks or more defines a major depressive disorder. Patients will experience at least five of the following symptoms nearly every day. These symptoms cause clinically significant distress or impairment in social, occupational, or other functioning. To be considered a major depressive disorder, psychotropic drugs or a general medical condition aren't the cause of these symptoms and they don't occur within 2 months of the loss of a loved one:

- Depressed mood (irritability in children and adolescents) most of the day, nearly every day
- Markedly diminished interest or pleasure in almost all activities most of the day, nearly every day, as indicated either by subjective account or observation by others
- Significant weight loss or gain
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feeling of worthlessness or guilt
- Impaired concentration or indecisiveness

How Do I Know if I Have Depression?

- 5 Symptoms Simultaneously
- Daily or nearly every day
- Different severity, frequency or duration of symptoms

- A depressed mood during most of the day, particularly in the morning
- Fatigue or loss of energy almost every day
- Feelings of worthlessness or guilt almost every day
- Impaired concentration, indecisiveness
- Insomnia (an inability to sleep) or
- Hypersomnia (excessive sleeping) almost every day

How Do I Know if I Have Depression?

- Markedly diminished interest or pleasure in almost all activities nearly every day
- Recurring thoughts of death or suicide (not just fearing death)
- A sense of restlessness or being slowed down
- Significant weight loss or weight gain
- Loss of interest in activities once enjoyed

General Population Depression in Adults

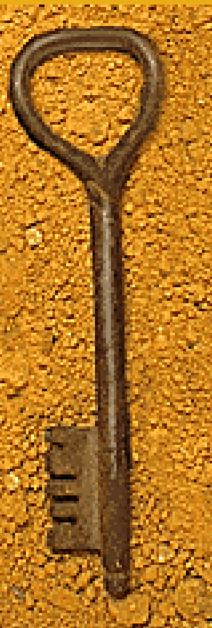
- Prevalence
  - 1.8-3.3% within past month
  - 6.7% within year MDD
  - 4.9-17.1% lifetime prevalence (Pignone, 2002)
- Women are 70 % more likely than men to experience depression during their lifetime
- Adults older than 65 range 15 to 20% (Ciechanowski, 2004)

General Population Depression in Adults

- Average age of onset is 32 years old.
- 50% treated in primary care
- Not uncommon to have an anxiety disorder and depression

- Major Depressive Disorder
  - 4% to 8% in adolescents
  - Male-to-female ratio of 1:1 during childhood
  - Male-to-female ration of 1:2 during adolescence
- By age 18 incidence is ~ 20%
- Subsyndromal symptoms of MDD - 5% to 10% of adolescents
- Dysthymic Disorder-prev of 1.6% to 8.0% in adolescents
- Each successive generation since 1940 is at greater risk of developing depressive disorders & that these disorders have their onset at a younger age

Depression in Children



- Prevalence
  - 0.3% of preschoolers
  - 2% elementary school-age children
- Ethnic prevalence

One study of 9863 students ages 10-16 years found

  - 29% of American Indian youth exhibited symptoms of depression
  - 22% of Hispanic,
  - 18% of Caucasian,
  - 17% of Asian-American,
  - 15% of African-American youth.

Depression in Children

- Treatment of depression in childhood can help to prevent mental health problems or drug and alcohol misuse in later life.
- Equal prevalence among young boys and girls *until* puberty; then 2:1 females to males
- Adults seen for depression can trace its origins to childhood/ adolescence

Intellectual Disability

- Intellectual disability (ID) is the term used to define a developmental disorder characterized by deficits in both
  - Intellectual (low IQ) less than 70
  - Adaptive functioning (activities of daily living, social, work, relationship).
- 1.5 to 2% of population in Western regions
- Replaced "mental retardation" in DSM-5
- Change led by renaming of organizations
  - 2003 President's Committee for People With Intellectual Disabilities
  - 2006 American Association on Intellectual and Developmental Disabilities

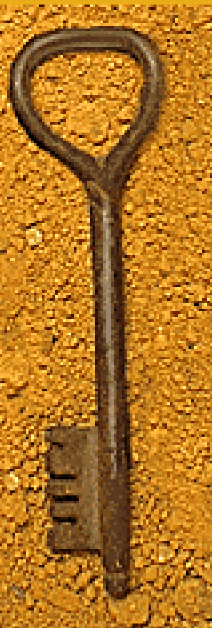
- Trisomy 21 (Down's syndrome) and detectable in chromosomal studies since 1959 most important chromosomal cause if I/DD

- Fragile X most common of inherited syndromes caused by a single-gene defect phenotype in males (Mefford, Batshaw & Hoffman 2012)

Mental Illness I/DD vs General Population

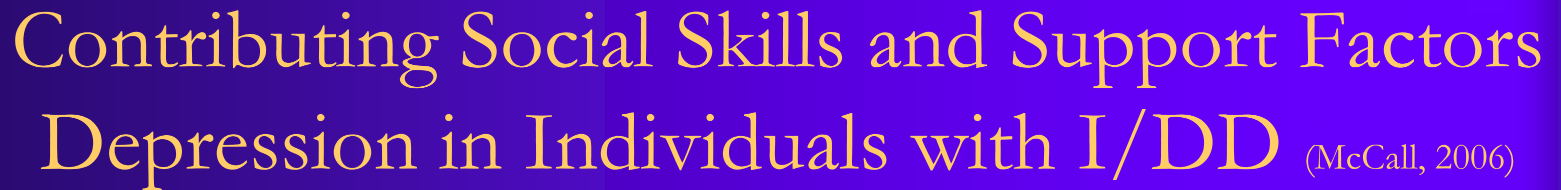
- Prevalence psychiatric disorders higher- 32-40%
- Easier to diagnose in mild I/DD than severe
- Rates of depression at least approach – if not exceed
- Typically more severe
- More difficult to diagnose
- Degree of variability of cases greater

(Aggarwal 2013)



Contributing Factors
Depression in Individuals with I/DD

- Biological and Etiological (i.e., Down syndrome)
- Cognitive (i.e., automatic negative thoughts)
- Educational:
  - Learned Helplessness
  - Outerdirectedness
  - Inattention
- Life Events:
  - Negative social conditions(ridicule, rejection, etc.)
  - Negative events without support
  - Common life transitions(i.e., puberty, high school graduation)



Contributing Social Skills and Support Factors Depression in Individuals with I/DD (McCall, 2006)

- Negative experiences (i.e., stigmatization, ridicule, infantilization) maintain negative cognitive patterns
- Lack of social, adaptive behavior skills
- Lack of social support/loneliness
- Lower levels of self-control have significantly predicted depressive symptoms in a group of 42 adolescents with mild mental retardation (McCall, 2006)
- Males: significant correlations between cooperation, assertion, and total social skills with depressive symptoms (McCall, 2006)
- Females: significant correlation with depressive symptoms and self-control (McCall, 2006)
- Means of depressive symptoms higher for students with MiMR in grades 11-12 but social skills correlations (self-control, cooperation, and overall) only for grades 9-10 (McCall,

Factors of Depression in Individuals with Intellectual Disability

Self-Awareness

- "They can tell when others look down upon them, they are hurt emotionally when people ridicule them, and they realize that their opportunities are restricted because others think they are incapable" (Reiss & Benson, 1984, p. 90)

Individuals with Intellectual Disability

Depression in Adults with ID

1980s

- General belief people with I/DD did not have a cognitive capacity to experience mental health problems
- Behavioral disturbances were attributable to their learning disability.

Last 25 years

- Significant interest and effort to understand and expand knowledge of mental health problems in I/DD
- Care shifted from state hospitals to community setting which
- Increases need for medical and psychiatric care in community
- Created barriers to accurate assessment and intervention

Today

- Accepted that people with I/DD experience mental illness as nondisabled do
- More vulnerable
- Studies measuring prevalence rates and factors I/DD
- Produce different and sometimes contradictory results

(Aggarwal 2013; Smiley, 2005)

Individuals with Intellectual Disability

Depression in Adults with ID

- Difficult to obtain accurate data..
- What interferes with obtaining accurate data?
  - Communication of internal state/symptoms difficult
  - Absence of recognition by caregivers/providers
  - Data obtained from different settings, study designs, definitions
  - Definitions of different severities of depression and ID

Epidemiology-

study of disorder and knowing distribution of a disorder
can increase understanding of the causes and how best to manage it

FIGURE 1: COMMONLY USED MEASURES OF DISEASE FREQUENCY

Measure	Definition
Point prevalence rate	Refers to the proportion of people in a defined population who are affected by the disorder at a given point in time.
Period prevalence rate	Proportion of people who are affected by a disorder at any time within a stated period.
Incidence rate	Measure of new episodes of illness: the proportion of formerly well subjects who developed an illness in a defined period of time (usually 1 year)
Relative Risk (RR)	The ratio of the incidence of an outcome in those that are exposed to a certain risk factor compared to the incidence in an unexposed group
Odds Ratio (OR)	The ratio of the odds of disease in exposed individuals relative to the unexposed
Number needed to treat (NNT)	Meaningful way of expressing the benefit of any intervention: relates to how many individuals need to be treated for one individual to benefit

Individuals with Intellectual Disability

Prevalence of Depression in Adults with ID

- 1.5 to 2 x higher than gen population
- Depression most common diagnosis for all levels of I/DD- up to 42% in some studies (Hurley, Folstein, Lam, 2003)
- Point prevalence (of depression is around 3–4% (Smiley, 2005).

Depression in Children & Adolescents w I/DD

- 1.5 to 13.7% - similar rates as nondisabled peers (Whitaker & Read, 2006)
- Adolescents with mild mental retardation- 16.7% with significant depressive symptoms (McCall, 2006)

What is the Reality?

- 62% of people with ID and mental health needs do not receive services (Fletcher, 1988)
- 75% of psychiatrists feel they do not have sufficient training, 39% would prefer not to treat (Lennox & Chaplin, 1996)
- Internal Barriers: communication, finances, lack of self-referral
- External Barriers: fragmentation between agencies, lack of professionals with training and desire

Physical Symptoms of Depression

High percentage of all patients with depression seeking treatment in a primary care setting report only physical symptoms

Makes depression very difficult to diagnose.

Very important to recognize if you care or work with I/DD

Its All About Neurotransmitters…

Chemical communication between neurons by movement across the synapse.

SUMMARY TABLE

MAJOR NEUROTRANSMITTERS AND THEIR EFFECTS

Acetylcholine (ACh)	Generally excitatory	Affects arousal, attention, memory, motivation, movement. Too much: spasms, tremors. Too little: paralysis, torpor.
Dopamine	Inhibitory	Inhibits wide range of behavior and emotions, including pleasure. Implicated in schizophrenia and Parkinson's disease.
Serotonin	Inhibitory	Inhibits virtually all activities. Important for sleep onset, mood, eating behavior.
Norepinephrine	Generally excitatory	Affects arousal, wakefulness, learning, memory, mood.
Endorphins	Inhibitory	Inhibit transmission of pain messages.

And Synapses!

Temporary Figure 3.4

Axon of sending (presynaptic) neuron

Neural impulse

Synaptic vesicles containing neurotransmitter

Terminal button

Neurotransmitter molecules

Synaptic cleft

Cell membrane of receiving (postsynaptic) neuron

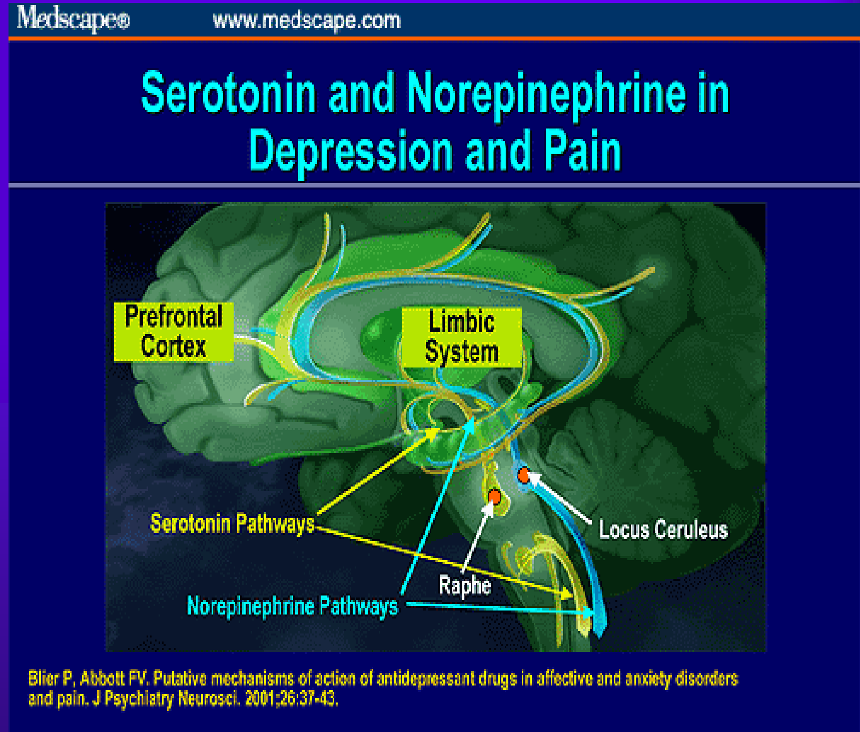
Receptor sites

Transmitter fits receptor site, binds to cell membrane, producing postsynaptic potential

Transmitter does not fit at receptor site, cannot bind to cell membrane

Neurotransmitters

- Neurotransmitters that influence both pain and mood are serotonin and norepinephrine.
- Dysregulation of these transmitters is linked to both depression and pain.
- Antidepressants that inhibit the reuptake of both serotonin and norepinephrine may be used as first-line treatments in depressed patients who present with physical symptoms



Physical Symptoms of Depression

- Chronic joint pain
- Limb pain
- Back pain
- Gastrointestinal problems
- Tiredness
- Sleep disturbance
- Psychomotor activity changes
- Appetite changes

Depressive Symptoms in Mild to Moderate I/DD

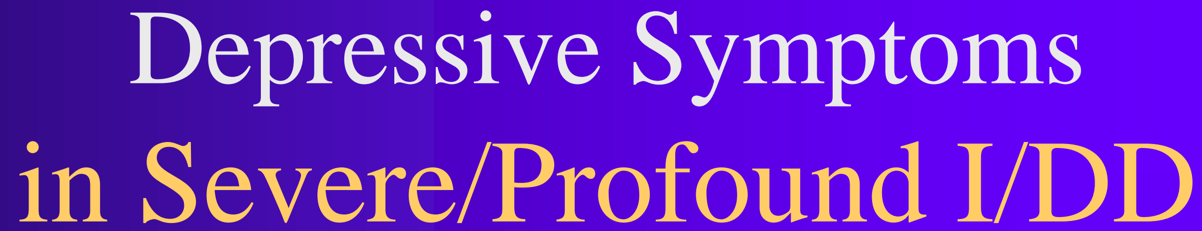
- Same full range of depressive symptoms as nondisabled peers
- Common symptoms:
  - Sad appearance
  - Depressed mood
  - Irritability
  - Fatigue
  - Hopelessness
  - Guilt
  - Loss of interest in activities
  - Tantrums
  - Self-injury (Aggarwal, 2013)

Depressive Symptoms in Moderate to Severe I/DD

- Changes in sleep patterns
- Depressed affect
- Withdrawal

- Expression of behavior may be different
  - Statements about self being "retarded"
  - Feelings of worthlessness
  - Not as interested in positive reinforcements
  - Perseveration about deaths, funerals of loved ones
  - Thoughts of death persistent

(Reudrich, Noyers-Hurley, & Sovner, 2001)



Depressive Symptoms in Severe/Profound I/DD

Particularly if nonverbal

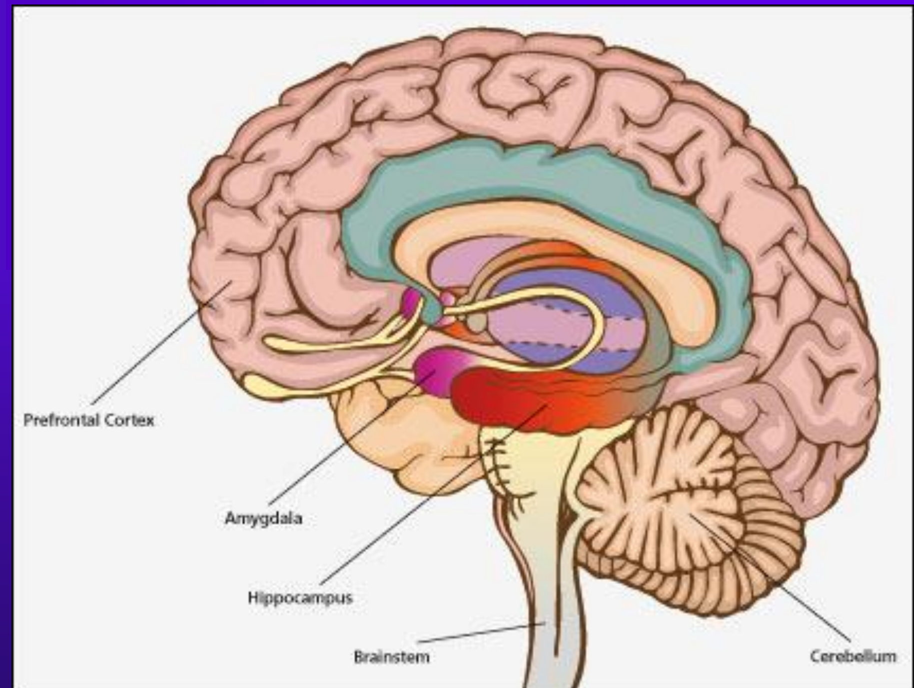
- Aggression
- Tantrums
- Screaming
- Self injurious behavior
- Crying
- Stereotypies
- Psychomotor agitation

Depression
Moderate Genetic Heritability

- 40-50% for major depression and may be higher for severe depression
- If parent has history of depression they have 2 to 3 x greater risk
- Recurrent depression- child or sibling has 4 to 5 x risk

Biology- no single brain structure or pathway

- Hippocampus – memory storage
- Smaller in people with hx of depression and has fewer serotonin receptors



- Theory
  - Excess production of cortisol and this can shrink hippocampus
  - Born with smaller

Life Events (Hastings, Hatton, Taylor & Maddison)

- Study of community 1100 dwelling adults with I/DD.
- Report from caregivers/parents who knew them well
- Assessed using the PAS-ADD Checklist
- Life events that occurred 12 months prior to data collections

Life Events

5 *most frequently* experienced

1. 15.5% -Moving residence
1. 9.0% -Serious illness of close relative or friend
2. 8.8%- Serious problem with close friend, neighbor or relative
1. 8.5%- Serious illness or injury to self
1. 8.3% -Death of close family friend or other relative

- 46.3%- Experienced one or more significant life events in the previous 12 months
- 17.4%- Experienced two or more
- Logistic regression analysis
  - one or more life events in the previous 12 months added significantly to the classification of psychiatric disorder
- Odds ratio for affective disorder given exposure to one or more life events was 2.23

(Hastings, Hatton, Taylor & Maddison, 2004)

Difficulty with Accurate Assessment

Why Is Depression Hard to See in Clients with I/DD?

- Atypical presentations
- Diagnostic limitations secondary to communication barriers,
- Lack of formal diagnostic tools
- Valid diagnostic information hard to obtain
- Difficulty describing internalizing symptoms
- Deficits in communication, social skills and intellectual functioning.
- Challenging behaviors may mask depression
- Limited number of empirical studies
- Lack of standardized assessments specific to diagnosing clients with IDs and psychiatric co morbidities

Modified diagnostic criteria proposed

Practitioner Issues

- Practitioners often feel inadequate to assess, diagnose and treat ID population, particularly if psychiatric issues in ID population.[8]
- 90.2% of psychiatrists felt inadequate to diagnose problems in I/DD population due to lack of training (Werner, 2006)
- Practitioner anxiety can often interfere with ability to provide good care.

Assessment

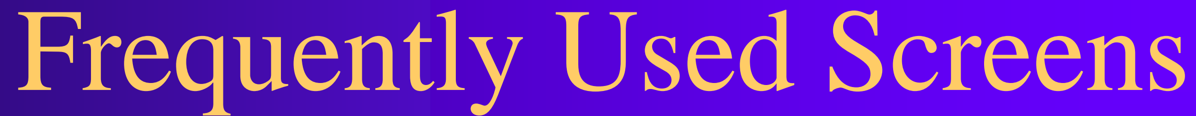
- Multi disciplinary
- Thorough assessment for possible physical cause of anxiety/agitation
- Applied behavioral analysis
- Multiple resources- home, work, family, particular those who know individual for long period of time
- Any recent trauma or anniversary or LOSS?

Assessment

- Collateral info more importation than from general population being evaluated

- Psychiatric Assessment Schedule for Adults with a Developmental Disability (PAS–ADD; Moss et al, 1993b:, Smiley 2005).
- Reasonable reliability and validity
- The PAS–ADD Checklist -for carers and staff to help decide if individual requires further assessment
- Useful screening tool for id possible cases of mental illness

- First scale for assessing psychopathology for persons with ID appeared in 1983 (Kazdin, Matson, & Senatore, 1983).
- Still widely used
- Many scales based on or cross validated
- Corresponding caregiver form



- Child Behavior Checklist (CBCL) Developmental Behavior Checklist (DBC)
- Diagnostic Assessment for the Severely Handicapped II (DASH-II)
- Nisonger Child Behavior Rating Form (NCBRF)
- PAS-ADD, Mini PAS-ADD, PAS-ADD 10
- Reiss Screen

- Self-report-
  - the Glasgow Depression scale
- Informant report-
  - Assessment of Dual Diagnosis
  - Reiss Screen for Maladaptive Behaviour
  - The Children's Depression Inventory
- Psychometrics
  - Valid and reliable
  - Still issues with sensitivity and specificity in the ID population
  - More study needed
    - (Herman & Evenhuis, 2010)

- Biological Psychological Social= BIO-PSYCHO-SOCIAL

Presenting complaint

Recent life events

Changes/moves

Medical History

Medication History

Psychiatric History

Trauma History

Family History

Physical

Possible Labs

Lab Tests

- TSH
- FT4
- ECG
- Urine Drug Screen
- Chem 7
- LFT
- Pregnancy test

Depression Assoc w/Medical Illness and/or Substance Abuse or Alcoholism

- **Cardiac disease**
- **Cancer**
- **Neurologic disease**
  Parkinson's disease
  Chronic headache
  Traumatic brain injury
  Stroke
  Dementias
  Multiple sclerosis
- **Metabolic disease**
  Electrolyte disturbances
  Renal failure
- **Gastrointestinal disease**
  Irritable bowel syndrome
  Inflammatory bowel disease
  Cirrhosis
  Hepatic encephalopathy
- **Endocrine disorders**
  Hypothyroidism
  Hyperthyroidism
  Cushing's disease
  Diabetes mellitus
  Parathyroid dysfunction
- **Pulmonary disease**
  Sleep apnea
  Reactive airway disease
- **Rheumatologic**
  Systemic lupus erythematosus
  Chronic fatigue syndrome
  Fibromyalgia
  Rheumatoid arthritis

Suicidality in I/DD

- Suicidal ideation and attempts 17 to 23% (Lunsky, 2004)
- Sample of 42 adolescents with mild MR showed 38% thought about killing themselves while nearly 5% wanted to do it (McCall, 2006)

Only two studies had systematically examined differences between suicidal and non-suicidal individuals with ID with regard to risk factors.

Limited research on intervention for suicidal behavior in the ID population, but professionals should consider risk factors for suicide in this population and intervene when suicidal risk/behavior is found.

Risk Factors for I/DD

- Hx of psychiatric hospitalization
- Comorbid physical disabilities
- Loneliness
- Sadness
- Depression or anxiety

- ✓ Be attentive
- ✓ Remain calm and do not appear threatened
- ✓ Stress a partnership approach
- ✓ Discuss suicide in a calm, reasoned manner
- ✓ Listen to the patient
- ✓ Emphasize that suicide causes a great deal

Suicide Assessment: Warning Signs

- Pacing
- Agitated behavior
- Frequent mood changes
- Chronic episodes of sleeplessness
- Actions or threats of assault, physical harm or violence
- Delusions or hallucinations
- Past suicide attempt
- Recent loss
- Threats or talk of death (e.g., "I don't care anymore," or "You won't have to worry about me much longer.")
- Putting affairs in order, such as giving possessions away or writing a new will
- Unusually risky behavior (e.g., unsafe driving, abuse of alcohol or other drugs)

Suicide Risks

Older than age 65

Male sex

White race or Native-American ethnicity

Single, divorced, separated, or widowed (especially without children)

Unemployment

History of admission to a psychiatric ward

Family or personal history of one or more suicide attempts

Drug or alcohol abuse

Severely stressful life event in recent past

Panic attacks or severe anxiety

Severe physical illness, especially of recent onset

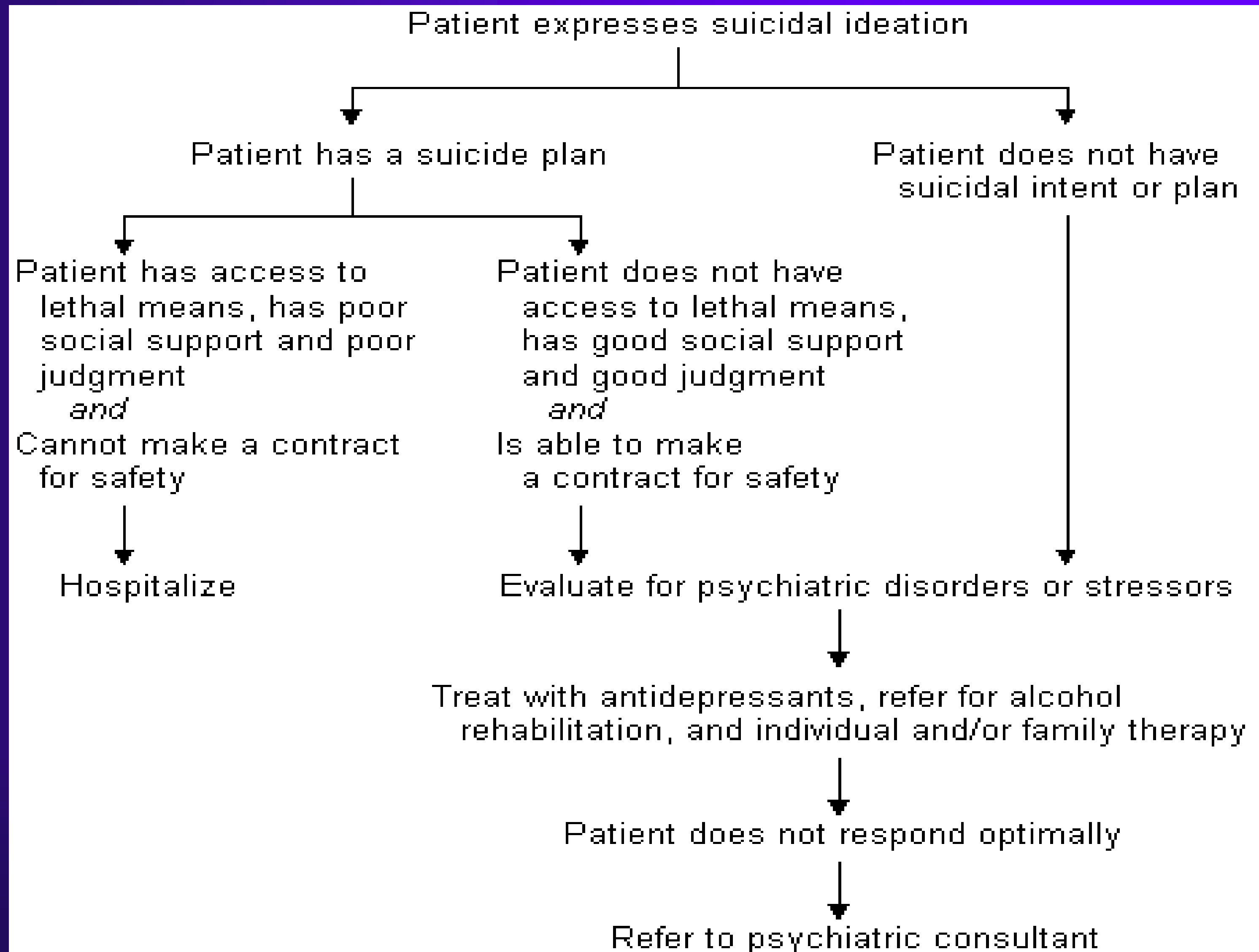
Severe hopelessness

Anhedonia

Specific plan for suicide

Access to firearms or other lethal means

Suicide Algorithm



Assisting Potential Suicidal Patients

- *Be attentive*
- *Remain calm and do not appear threatened*

- *Stress a partnership approach*
- *Discuss suicide in a calm, reasoned manner*

- *Listen to the patient*
- *Emphasize that suicide causes a great deal of pain to family members*

Final Recommendations

- Watch for warning signs and do not disregard them given the diagnosis of intellectual disability
- Incorporate family input and involvement at any level of intervention
- Consider the individual: self-awareness, self-perception, involvement and various types of activities, etc.
- Consider the system: training, awareness, understanding of parents, educators, and other health facilitators

- Psychotherapy
  - Can be successful with modifications
  - Play media, art, drama
  - Focus on present, goals, impact of MR
  - Individual, group, and family
  - Has been used successfully with clients with MR but limited studies

Psychotherapy Modifications (McCall)

- Concrete, structured format
- Simplified concrete language

- Therapist with more direct role
- Slower pace, shorter sessions

- Frequent checks for understanding, repetition
- Repeated, clear permission to express emotions

- Recognize, address impact of disability, repeated negative life experiences, external systems (Levitas & Gilson, 1989; Lynch, 2004)

- Play media must be age-appropriate
  - Act out TV show vs. playing with dolls
  - Role play
- Increased dependency on therapist
- Inappropriate "rescue" mentality
- Goals ignoring the individual
  - Tailor to reality and experiences, including disability
  - Encourage independence in setting, meeting

Group Psychotherapy (McCall)

- Goals: improve self-image, acceptance of disability, understanding of disability, coping skills
- Effective for multiple purposes across levels of mental retardation
- 6-8 individuals w/ similar cognitive and verbal abilities, motivation, needs (Monfils, 1989)
- Develop relationship, encourage self-disclosure
- Discussion, problem solving, role play, reinforcement, feedback, social outings

An Example of Group Psychotherapy

(McCall)

- Adolescents with mental retardation (Thurneck, Warner, & Cobb, 2007)
- Improve coping strategies for failure
- Group listening games, discussion of negative experiences
- Visits by students w/out disabilities to share experiences – commonality
- Increased sense of belonging

- Share common experiences of disability
- Healthy emotional release with support, encouragement of others
- Strong sense of group cohesion
- Secure environment to explore feelings, problems
- Increased self-esteem, self-image, life strategies

- Self-Instruction
  - Encourage use of positive self-statements with prompts, reinforcement
  - Internalized statements change cognitions and behavior
- Problem Solving
  - Direct instruction, practice, role play
- Modeling
  - Observe models, practice behavior

CBT Approaches for Depression with Intellectual Disability

- Behavioral Techniques
  - Manipulation of setting events
  - Positive Reinforcement
  - Teaching of alternative desired behaviors

- Cognitive Techniques
  - Positive self-statements
  - Self-monitoring of thoughts, mood

- 2 hours 1x/week for 5 weeks
- Group format: adults with mild-moderate MR
- Emphasis
  - meaning of depression
  - support networks
  - link between thoughts and emotions
  - development of positive self-statements
  - role play for problem solving
  - development of realistic goals
- Improved symptoms, automatic thoughts; persisted 3 months after

(McCabe, McGillivray, & Newton, 2006)

- Social Skills: modeling, role play with practice and feedback
- Relaxation: deep breathing, guided imagery
- Assertiveness: instruction, modeling, practice
  - Differentiate from passivity, aggression
- Anger Management: coping statements, problem solving, relaxation

Coping-Based Therapies

- Bereavement
  - Unresolved grief, loss
  - Encouraged to hide emotions, not attend events
  - Education about death, participation loss rituals and sharing, encouragement of family contact, coping strategies, sharing objects, journaling, writing letters, visiting sites, sense of control over own life
  - Reduction of depressive symptoms across all levels of MR (Dowling, Hubert, White, & Hollins, 2006; Stoddart, Burke, & Temple, 2002)

Individuals with Intellectual Disability

Medication Treatment

Not first line

Ideal is to have therapy AND medication

I/DD increased sensitivity to side effects/and or disinhibition

Accurate Diagnosis a MUST

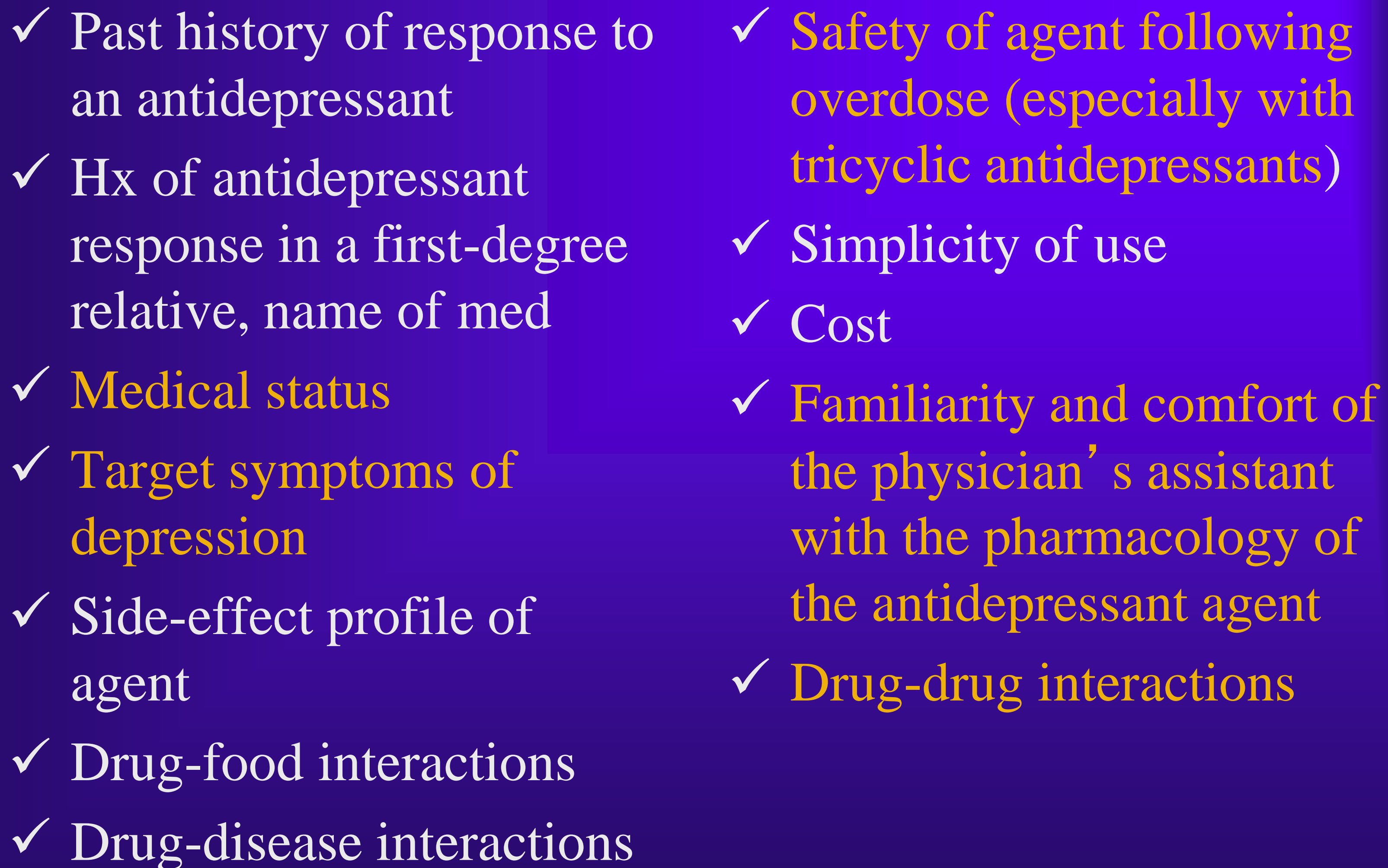
- Symptom driven
- Diagnosis driven
- Co-morbidity
- Best Evidence
- Age of patient
- Side effect profile
- Ease of administration/dosing
- Compliance Issues
- Safety issues, i.e., suicidality
- Belief system of parent and child
- Cultural issues

Depressive Disorder Differential

- ✓ Somatic complaints may contain hidden signs of depression
- Sx-loss of energy or fatigue unexplained pain
- ✓ GI sx
- ✓ headache
- ✓ insomnia
- ✓ dizziness
- ✓ palpitations heartburn
- ✓ numbness
- ✓ loss of appetite
- ✓ PMS
- ✓ Insomnia, specifically early morning awakening, is a reliable and early indicator of depression

- Dx made after medical etiology ruled out.
- ✓ Hypothyroidism
- ✓ Neurosyphilis
- ✓ Substance abuse
- ✓ Major organ system disease
- ✓ Multiple sclerosis
- ✓ Medications
  - antihypertensives
  - anticonvulsants
  - beta-blockers
  - steroids
  - chemotherapy
  - levodopa
  - benzodiazepines

Factors to Consider When Selecting an Antidepressant



- ✓ Past history of response to an antidepressant
- ✓ Hx of antidepressant response in a first-degree relative, name of med
- ✓ Medical status
- ✓ Target symptoms of depression
- ✓ Side-effect profile of agent
- ✓ Drug-food interactions
- ✓ Drug-disease interactions
- ✓ Safety of agent following overdose (especially with tricyclic antidepressants)
- ✓ Simplicity of use
- ✓ Cost
- ✓ Familiarity and comfort of the physician’s assistant with the pharmacology of the antidepressant agent
- ✓ Drug-drug interactions

Pharmacology

- Selective Serotonin Reuptake Inhibitors or SSRI's- inhibit the reuptake of serotonin in the synapse so it is more available to the neuron, thereby increasing a sense of well being

SSRIs

✓ Citalopram (Celexa)
20-60 mg

✓ Fluoxetine (Prozac)
10-80 mg

✓ Paroxetine (Paxil)
10-60 mg

✓ Sertraline (Zoloft)
50-200 mg

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Common Side Effects

- ✓ Headache
- ✓ GI upset, nausea, diarrhea
- ✓ Mild sedation w/some
- ✓ Sexual dysfunction, decrease libido
- ✓ Sweating

Serious Side Effects

- ✓ Withdrawal Syndrome
- ✓ Serotonin Syndrome
- ✓ Mania
- ✓ Sz (rare)
- ✓ Hyponatremia
- ✓ Bleeding
- ✓ EPS

Depressive Disorders

Pharmacology

- ✓ Bupropion (Wellbutrin, and Sustained-release)

Start:100 mg bid, incr after 3d75-150mg q d Max 450mg qd

SR-150 bid, Max400 mg

Contraindicated w/hx of seizures, bulimia, anorexia nervosa

SE-headaches, jitteriness, insomnia, tics, sz at doses over 450mg/day

- ✓ Trazodone (Desyrel)

Start: 150 mg/d, incr by 50mg q 3 d Max 400mg/d, take w/food

SE- sedation, dizziness, bitter taste, tremor

Serious-hypotension, *priapism,* syncope

- ✓ Venlafaxine (Effexor)

Start: 37.5 mg bid, incr dose q 4d; max 375 mg/d; take w/food; taper dose over 2 wk period

- ✓ Venlafaxine, extended-release (Effexor XR)

Start: 37.5 mg qd, incr by 75 mg q 4-7 d; max ww5mg/day taper by 75mg/wk

SE-headache, hypertension, insomnia

Serious: Sz

Follow-up Visits

- Med chosen and initiated, allow 4-6 wks for full effectiveness
- Severely depressed -weekly follow-up visits
- Less severe- every 10 to 14 days during the first six to eight weeks of treatment.
- Telephone visits can be effective
- After symptoms begin to remit-more severely depressed patients can be seen every four to 12 weeks.
- The patient should be informed that the med provider is available between visits to address his or her concerns

Maintenance

- After remission of a first episode of depression, four to nine months of continuation therapy at the same dosage is recommended
- After remission of a second episode, maintenance therapy for at least one year, and possibly two, is appropriate
- After a third episode, long-term maintenance treatment, possibly indefinitely, may be indicated
- Patients with risk factors for recurrence (e.g., frequent relapses with severe episodes associated with suicidality and psychosis, poor recovery between episodes) may require lifelong therapy

Maintenance (continued)

- 6 weeks is the optimal therapeutic trial
- Adequate dosage but has not responded or has experienced only *minimal* relief at 6 weeks *reassess diagnosis of depression* and *adequacy of treatment*
- Underlying substance abuse and/or the presence of a general medical condition or a chronic social stressor, such as domestic violence, can contribute to treatment failure
- If none of these are found on reassessment, at weeks 4 to 6 the dosage should be *increased*
- If response is *still inadequate* after 8 weeks of treatment, the *dosage* may need to be *adjusted* or *another medication* selected.

Summary

- Depression more of a problem for I/DD than general population
- Often missed due to inherent problems assessment and ability to disclose internal states
- Good assessment gives proper diagnosis
- Evidence based tools best
- Many therapies can be quite helpful in I/DD
- Meds are SECOND line and in combination with therapy
- Collaborate and consult

Sheila C. Hutton Website
http://www.intellectualdisability.info

Site Map Accessibility Contact

Understanding Intellectual Disability & Health

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An understanding of the nature of intellectual disability is essential for health care professionals, who are required to support equal access to their services for all disabled people.

Changing Values

Diagnosis

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Senior editorial team have clinical and academic experience spanning the last 30 years

CATEGORIES

- News
- Changing Values
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- Physical Health
- Mental Health

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Online Resources

- National Alliance for the Mentally Ill
  800-950-6264
  www.nami.org
- National Depressive and Manic Depressive Association
  800-826-3632
  www.ndmda.org
- National Foundation for Depressive Illness
  800-239-1265
  www.depression.org
- National Institute of Mental Health
  301-443-4513
  www.nimh.nih.gov
- National Mental Health Association
  800-969-NMHA
  www.nmha.org
- Substance Abuse and Mental Health Services Administration U.S. Department of Health and Human Services
  301-443-4795
  www.samhsa.gov