Unlocking and Treating Depression in Adults with Intellectual Disabilities

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Overall Goal

- Discuss depression in intellectually/developmentally delayed (I/DD) and non I/DD populations.

Specific Objectives

For the I/DD population:

- 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 psychiatric medications** for depression

Depression in Non I/DD:

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

Definition of Depression

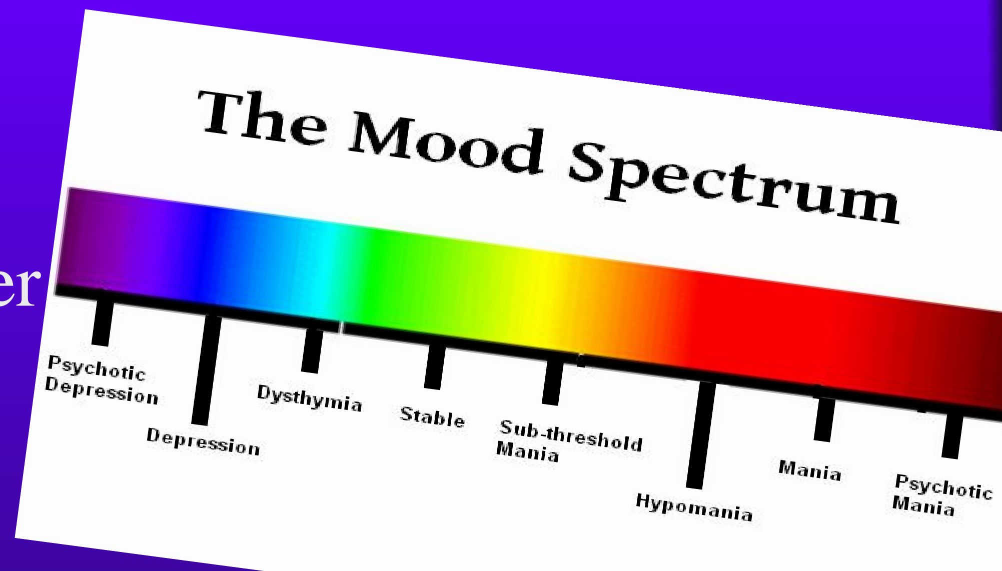
- Normal human emotion we sometimes call "depression" is a common response to a loss, failure or disappointment.
- Major depression is different.
  - Serious emotional and biological disease that affects one's thoughts, feelings, behavior, mood and physical health.
  - Life-long condition in which periods of wellness alternate with recurrences of illness
  - May require long-term treatment to keep symptoms from returning, just like any other chronic medical illness.

Depression Facts

- Estimated 25 million Americans affected by MDD in a given year
- By 2020 depression will be the leading cause of disability and the 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% with depression are seen by their PCP and up to 50% are misdiagnosed

Depressive Illness on a Spectrum

- Transient Sadness
- Grieving
- Adjustment Disorder
- Dysthymia
- Major Depressive
- Disorder
- Bipolar Illness



Upper limit of "normal" mood (happiness, joy)

Mania

Hypomania

"Good times"

"Bad times"

Subsyndromal depression

Lower limit of "normal" mood (sadness, grief)

Major depression

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.

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
- Recurrent thoughts of death or suicide.

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)

How Do I Know if I Have Depression?

- 5 Symptoms Simultaneously
- Daily or nearly every day
- For 2 wks or more
- 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

- 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

Depression in Non I/DD Adults

- Prevalence Major Depression
  - In past month 1.8-3.3%
  - In past year 6.7%
  - Lifetime prevalence of 4.9-17.1% (Pignone, 2002)
- Women are 70 % more likely than men to experience depression during their lifetime
- 15 - 20% of adults older than 65 experience depression (Ciechanowski, 2004)

Depression in Non I/DD Adults

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

Depression in Non I/DD Adolescents

- Major Depressive Disorder
  - Prevalence 4% - 8% in adolescents
  - 1:1males to females ratio before puberty
  - 1:2 male to female ratio after puberty
- By age 18 incidence is ~ 20%
- Dysthymic Disorder-prev of 1.6% to 8.0% in adolescents
- Since 1940 each successive generation is at greater risk of developing depressive disorders & depressive disorders have their onset at a younger age

Depression in Non I/DD 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 Non I/DD Adolescents

- Treatment of depression in childhood can help to prevent mental health problems or drug and alcohol misuse in later life.
- Adults seen for depression can trace its origins to childhood/ adolescence

bing

Depression in Adults with I/DD

Definition:
Intellectual Disability

- Intellectual disability is the term used to define a developmental disorder characterized by deficits in both:
  - Intellectual ability (low IQ) less than 70
  - Adaptive functioning
    - Activities of daily living
    - Social
    - Work
    - Relationship

Depression in Adults with I/DD

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/effort to understand and expand knowledge mental health problems in I/DD
- Care shifted from state hospitals to community setting w/o experienced providers
-
- Increased need for medical and psychiatric care in community
- Created barriers to accurate assessment and intervention

(Aggarwal 2013; Smiley, 2005)

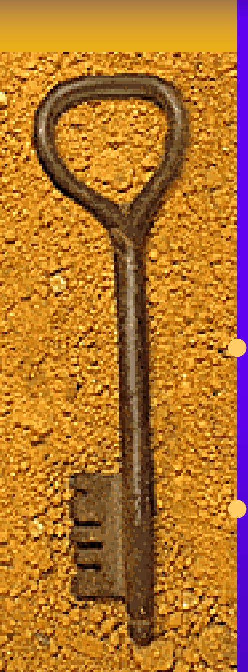
Depression in Adults with I/DD

Today

- Accepted that people with I/DD experience mental illness as non I/DD
- More vulnerable
- Studies measuring rates and factors I/DD produce different and sometimes contradictory results

Prevalence and Progress: Intellectual Disability

- Prevalence of I/DD 1.5 to 2% of population in Western countries
- DSM 5 replaced "mental retardation" with intellectual disability
- Change led by renaming of organizations
  - 2003 President's Committee for People With Intellectual Disabilities
  - 2006 American Association on Intellectual and Developmental Disabilities



Individuals with Intellectual Disability

Depression in Adults with I/DD

- 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 I/DD

Most Common Genetic Causes of I/DD

- Trisomy 21 (Down syndrome)
  - 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 Non I/DD

- Prevalence of psychiatric disorders in I/DD higher
- Typically mental illnesses are more severe in I/DD
- Rates of depression in I/DD at least approach – if not exceed
- Often easier to diagnose mental illnesses in mild I/DD vs severe I/DD
- More difficult to diagnose
- Degree of variability of cases greater

(Aggarwal 2013)

Depression in I/DD
Contributing Factors

- 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)

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)

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 I/DD

- 1.5 to 2 x higher than non I/DD
- 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).

Individuals with Intellectual Disability

Depression in Children & Adolescents w I/DD

- 1.5 to 13.7% - similar rates as nondisabled peers (Whitaker & Read, 2006)
- 16.7% of adolescents with mild mental retardation in one study had 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…

The chemical communication between neurons of neurotransmitters across the synapse and these are implicated in one's mood…..

SUMMARY TABLE

MAJOR NEUROTRANSMITTERS AND THEIR EFFECTS

Neurotransmitter	Type	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

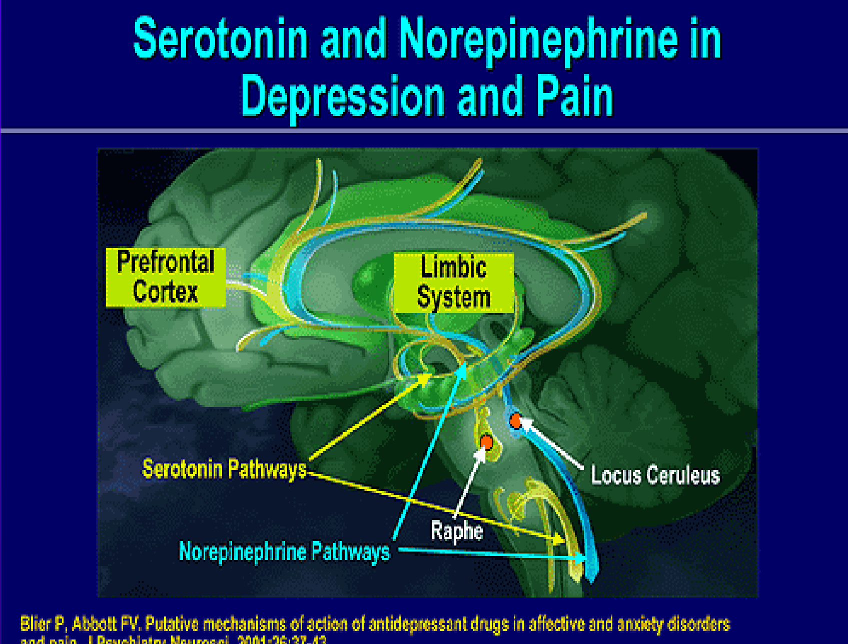
Receptor sites

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

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

Neurotransmitters

- Serotonin and epinephrine neurotransmitters influence both pain and mood.
- 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
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
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)

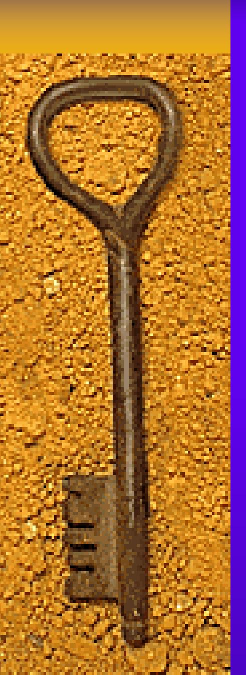
Depressive Symptoms in Severe/Profound I/DD

Particularly if nonverbal

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

Causes of Depression?

- Genetic
- Biological
- Environmental

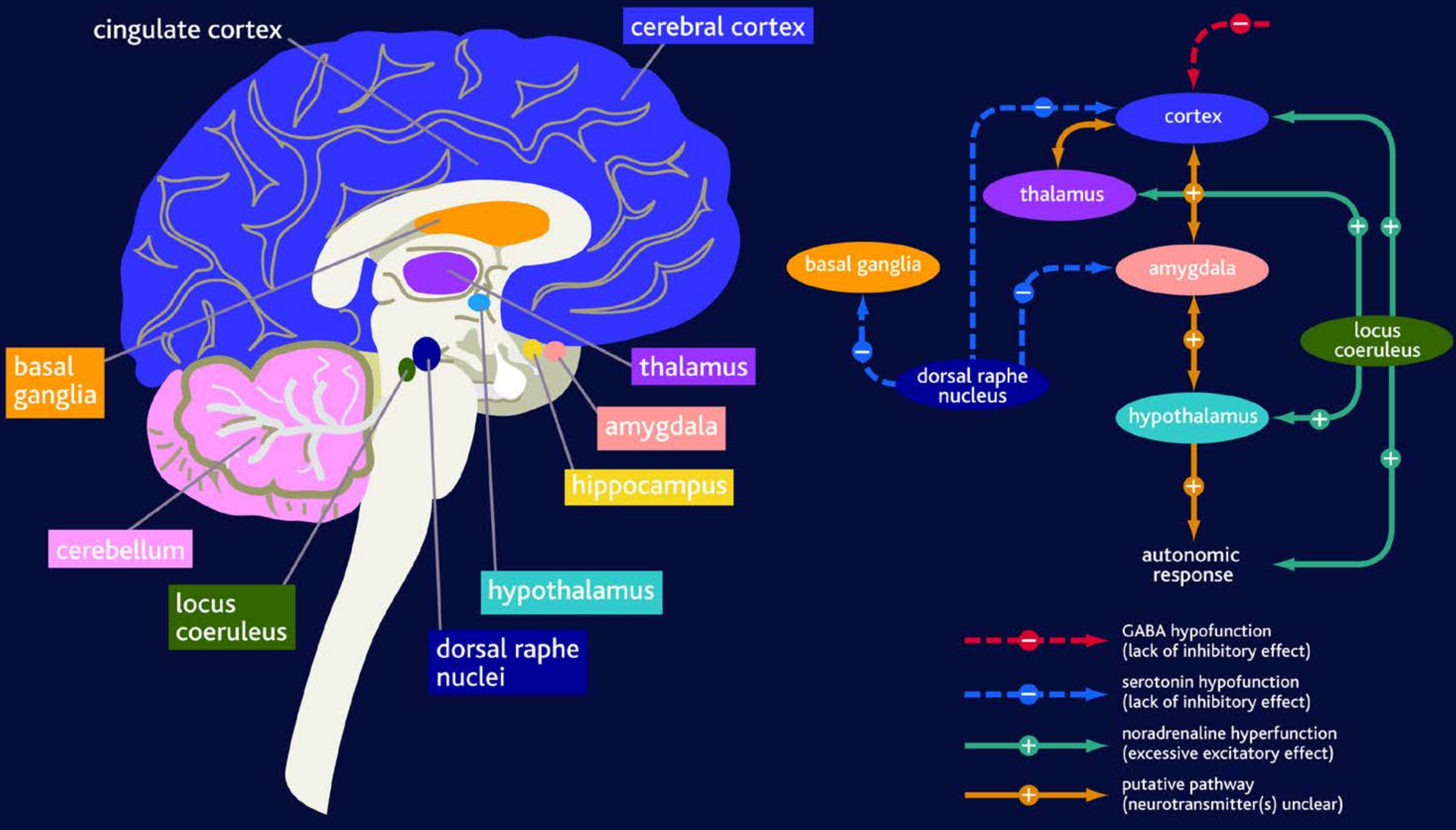


Depression
Moderate Genetic Heritability

- 40-50% inheritability for major depression and may be higher for severe depression (ref)
- Parent has history of depression child has

  2 to 3 x greater risk
- Parent has recurrent depression- child or sibling has 4 to 5 x risk

Brain Structures
Implicated in Mood Regulation



Normal regulation - may depend on the integrity of pathways linking the paralimbic frontal cortex and the basal ganglia.

Two Systems Act in Concert

1. orbitofrontal–amygdala network that supports emotions and moods
2. hippocampal–cingulate system that supports memory encoding and explicit processing (among other functions)

Key regions implicated in mood disorders

a b c d

(a) Orbital prefrontal cortex and Ventromedial prefrontal cortex
(b) Dorsolateral prefrontal cortex
(c) Hippocampus and Amygdala
(d) Anterior cingulate cortex

Davidson et al, 2002, Annu. Rev. Psychol.

Hippocampus

-not solely responsible for all of symptoms seen in depression

-highly plastic

-stress-sensitive

-could play a central role in depressive illness

Key regions implicated in mood disorders

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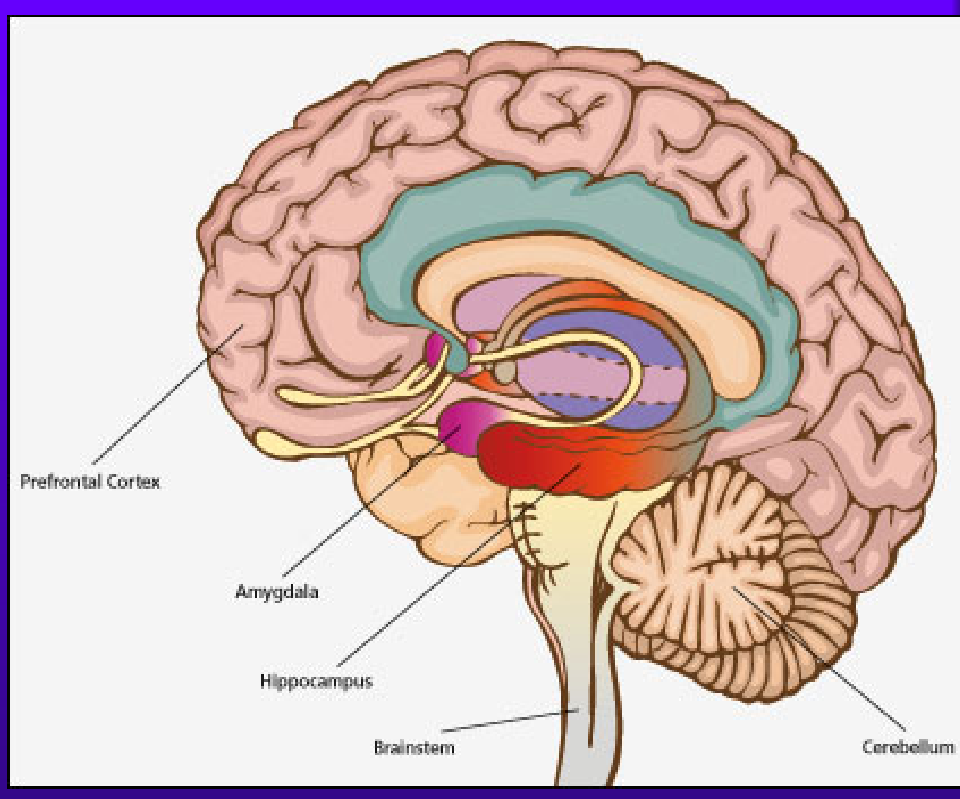
Davidson et al, 2002, Annu. Rev. Psychol.

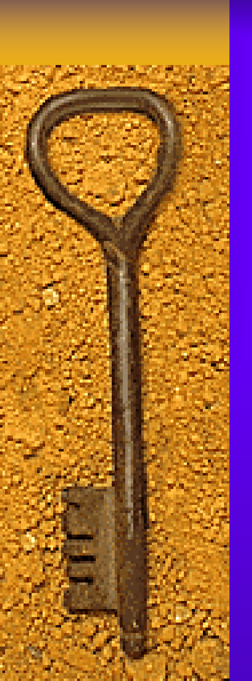
Biology
No Single Brain Structure or Pathway

Hippocampus -

Memory storage

- Smaller in people with hx of depression most frequently reported neuroimaging finding
- Have fewer serotonin receptors
- WHY?
- Theory of excess production of cortisol which can shrink hippocampus or
- Born with smaller hippocampus





Life Events (Hastings, Hatton, Taylor & Maddison 2004)

- Study of community 1100 community dwelling adults with I/DD.
- Report from caregivers/parents who knew them well
- Assessed using the PAS-ADD Checklist (Psychiatric Assessment Schedule for Adults with a Developmental Disability)
- 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

- One or more life events in the previous 12 months added significantly to the classification of psychiatric disorder

- One or more life event in this study contributed 2.23 x to the development of an affective disorder.

(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 used proficiently and consistently
- 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

Proposing modified diagnostic criteria

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.

Individuals with Intellectual Disability

Assessment for Depression

- Biological Psychological Social= BIO-PSYCHO-SOCIAL

Presenting complaint
Recent life events

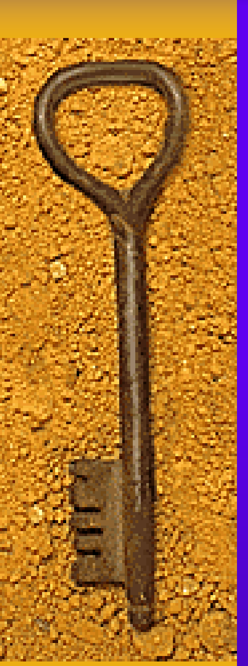
Changes/moves
Medical History

Medication History
Psychiatric History

Trauma History
Family History

Physical
Possible Labs

Lab Tests



- TSH
- FT4
- ECG (TCA)
- Urine Drug Screen
- Chem 7
- CBC w/diff
- LFT
- Pregnancy test
- Fasting lipids/glucose

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

Assessment

- Multi disciplinary
- Thorough assessment for possible physical cause of behavior/agitation that might mask depression
- 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 non I/DD being evaluated.

Individuals with Intellectual Disability

Assessment for Depression

- 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 to identify possible cases of mental illness

Psychopathology Instrument for Adults with Mental Retardation (PIMRA).

- 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 with
- Corresponding caregiver form

Frequently Used Screens

- 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

Depression Scales I/DD

- 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)

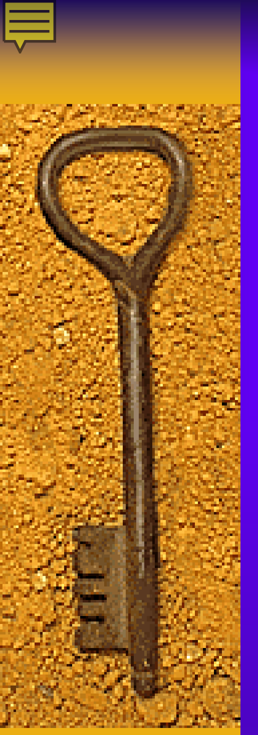
Depression Assoc w/Medical Illness and/or Substance Abuse or Alcoholism

- ✓ **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

Suicide

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 (McCall, 2006)



A Review of Suicidality in I/DD

(Merrick, Merrick & Lunsky, 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 in the I/DD population
- Professionals should consider risk factors for suicide w/I/DD
- Intervene when suicidal risk/behavior is found.

Risk Factors for I/DD

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

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

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

Patient expresses suicidal ideation

Patient has a suicide plan

Patient does not have suicidal intent or plan

Patient has access to lethal means, has poor social support and poor judgment
and
Cannot make a contract for safety

Hospitalize

Patient does not have access to lethal means, has good social support and good judgment
and
Is able to make a contract for safety

Evaluate for psychiatric disorders or stressors

Treat with antidepressants, refer for alcohol rehabilitation, and individual and/or family therapy

Patient does not respond optimally

Refer to psychiatric consultant

Suicide
Summary 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

Treatments and Interventions

- 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, 2006)

- 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)

Psychotherapy Precautions (McCall, 2006)

- Play media must be age-appropriate
  - Act out TV show vs. playing with dolls
  - Role play
- Increased dependency on therapist
- Therapist should not display inappropriate "rescue" mentality
- Goals do not ignore the individual
  - Tailor to reality and experiences, including disability
  - Encourage independence in setting, meeting

Group Psychotherapy (McCall, 2006))

- 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

- 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

Group Psychotherapy: Advantages

- 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

CBT Approaches for Depression with Intellectual Disability

- 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 in I/DD

- Behavioral Techniques
  - Identification and manipulation of setting events
  - Positive Reinforcement
  - Teaching of alternative desired behaviors
- Cognitive Techniques
  - Positive self-statements
  - Self-monitoring of thoughts, mood

Depression in I/DD
CBT Example

- 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; benefits persisted 3 months after group ended

(McCabe, McGillivray, & Newton, 2006)

Skills Training Approaches

- 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 with I/DD

- Bereavement in I/DD
  - Prolonged, atypical grief, often unrecognized
  - Often encouraged to hide emotions, not attend events
  - Randomized to two different therapeutic interventions
    1. Traditional Counseling by volunteer bereavement counsellors
    2. Integrated intervention by carers offering specific bereavement support
    - Content: 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

Prescribing of Medications

- 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 (TCA)

- Belief system of parents and I/DD

- Cultural issues

Additional 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
- ✓ Drug-food interactions
- ✓ Drug-disease interactions
- ✓ Safety of agent following overdose (especially with tricyclic antidepressants)
- ✓ Cost
- ✓ Familiarity and comfort of the physician’s assistant with the pharmacology of the antidepressant agent
- ✓ Drug-drug interactions

Pharmacology

<u>Selective Serotonin Reuptake Inhibitors/</u> SSRIs-

- 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 & weekly (Prozac) 10-80 mg
- ✓ Paroxetine (Paxil) 10-60 mg
- ✓ Sertraline (Zoloft) 50-200 mg
- ✓ Fluvoxamine & ER (Lexapro) 25-100

SSRI Potential Side Effects

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

Pharmacology

- ✓ Bupropion (Wellbutrin) SR

norepinephrine/dopamine reuptake inhibitor

Start:100 mg bid or LOWER, incr after 3d 75-150mg 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)
  norepinephrine/serotonin/dopamine reuptake inhibitor

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

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 population
- Often missed due to inherent problems assessment and inability 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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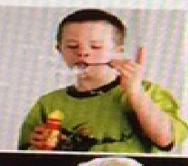
An understanding of the nature of intellectual disability is essential for health care professionals, who are required to support equal access to their services for all disabled people.

Changing Values


Diagnosis

Family

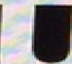
Life Stage

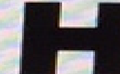
Physical Health

Mental Health

Complex Disability

How To...





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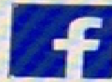

ABOUT THIS SITE

Ideal learning resource for medical, nursing and other healthcare students
Everyone working in healthcare will find invaluable information on this site
Senior editorial team have clinical and academic experience spanning the last 30 years

CATEGORIES

- News
- Changing Values
- Diagnosis
- Family
- Life Stages
- Physical Health
- Mental Health

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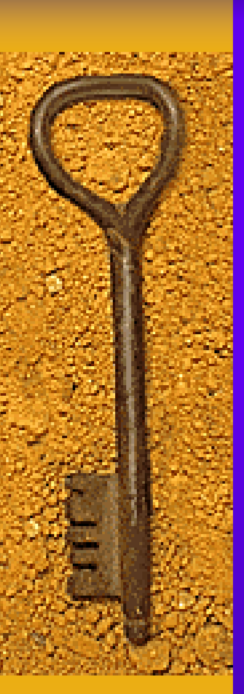

Online Resources

- 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

- Sheila C. Hutton Website

http://www.intellectualdisability.info

- National Institute of Mental Health
301-443-4513
www.nimh.nih.gov

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