Atypical Presentation of Anxiety in a patient with Intellectual Disability: A case report and brief review of literature

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Abstract

Objective: The diagnosis of psychiatric illness in patients with ID remains clinically challenging in several clinical situations owing to the patient’s limited intellectual functioning and adaptive behavior. Hence, this may lead to different and atypical manifestations of psychiatric symptoms and signs in these patients.

Method: Here, we present a case of a 17-year-old boy with moderate intellectual disability who presented to us with chief complaints of dysphagia for 2 months. Personal history is indicative of delayed milestones and difficulty in learning simple tasks. Premorbid temperament revealed anxious traits in the child. On MSE affect was distressed, speech was decreased in volume, psychomotor activity was increased and thinking revealed pre-occupation with symptom. Intelligence revealed poor general fund of knowledge and poor arithmetic ability. Insight was absent (Grade I).

Results and Discussion: On the basis of history and MSE, an unspecified diagnosis of an anxiety disorder (F41.9) was kept. The patient was started on treatment Tab Mirtazapine 7.5 mg ½ BD. The patient showed significant improvement following the initiation of treatment. Patients with intellectual disability have difficulty in expressing their psychological symptoms in words at times and present with atypical symptoms of the underlying disorder. This delays their diagnosis and appropriate management. Due to lack of reporting of psychological symptoms, the patient often continues seeking treatment from general practitioners, which leads to loss of time and money.

Conclusion: Physicians and psychiatrists themselves need to be more watchful when evaluating a patient with intellectual disability due to the atypical presentation of symptoms.

INTRODUCTION

The diagnoses of psychiatric illnesses are mainly based on good clinical history taking, interviewing and observational skills. However, psychiatric signs and symptoms are often non-specific, and it is a constellation of symptoms along with clinical wisdom, treatment response and outcome that help in understanding the diagnostic context of a case. People with intellectual disability (ID) have higher rates of psychiatric illnesses in comparison to general population. The diagnosis of psychiatric illness in patients with ID remains clinically challenging...
in several clinical situations owing to the patient's limited intellectual functioning and adaptive behavior.\(^2\) Hence, this may lead to different and atypical manifestations of psychiatric symptoms and signs in these patients (Table 1). In such a case, information needs to be collected from multiple sources, and careful observation of clinical course along with an understanding of alternations in the psychopathology of psychiatric disorders in cases with ID is needed. Vigilant behavioral observation, repeated empathetic interactions with patient, detailed family interviews and response to treatment are often helpful in establishing a diagnosis and management plan.

Patients with a moderate level of intellectual disability have a relative risk of 2.8–4.5 of having another comorbid mental disorder.\(^3\) Research done in specific areas showed that Schizophrenia and intellectual disability (ID) co-occur three times more than would be expected by chance. The limited studies available show the clinical picture varies in children with intellectual disabilities, they have a predominant picture of negative symptoms as compared to patients with normal intelligence.\(^4,5\) Similarly, studies done in patients having depression with subnormal intelligence revealed a clinical picture different from the usual presentation of depression. Patients with ID did not report the core symptoms of depression as low mood but instead had more of behavioral problems. With increasing disability, there was a move towards ‘behavioral depressive equivalents’ such as aggression, screaming and self-injurious behavior\(^6\) symptoms of depressed affect and sleep disturbance were significantly different between the groups. While symptoms in people with mild ID were reflected in the standard diagnostic criteria, this was not the case in people with moderate and severe ID. With increasing disability there was a move towards ‘behavioral depressive equivalents’ such as aggression, screaming and self-injurious behaviour. Diagnostic criteria for depression among people with severe ID, should place more emphasis on behavioural ‘depressive equivalents’. Patients having anxiety disorder also presented with behavioral problems like agitation, crying, regressive behavior and inability to express anxiety in words.\(^7\) Hence a similar presentation makes it difficult for the clinician to delineate the underlying illness.

### Case Report

Here, we present a case of a 17-year-old boy with moderate intellectual disability who presented to us with chief complaints of dysphagia for 2 months. The patient is a young adolescent male currently studying in the ninth standard, he was well adjusted to his routine way of living 2 months back when his family members noticed that he started having difficulty in swallowing food. One evening, the patient did not have lunch and started breathing heavily with hands on his chest. After 10–15 minutes, he started pacing around the house rapidly. On being asked what happened, he held his neck and reported pain and difficulty in breathing. This episode lasted for 30–40 minutes, following which the patient calmed down and started interacting normally with the family members. However, the patient refused to accept any solid food, as he felt food would get stuck in his throat. The patient started having such episodes daily, initially he would have 1–2 episodes per day which gradually increased to 3–4 episodes per day over a period of 2 month. The episodes would usually occur in the afternoon. The intensity of these episodes also increased. During the episode the patient would tie a cloth around his neck and try to fasten it and had to forcefully stop. On being questioned, he reported pain in chest and neck along with breathlessness. The patient also had crying spells 2–3 times during the day, the reason for which he was not able to explain whenever asked by the family members.

During the course of illness, the family members noticed that the patient's food intake reduced sig-
nificantly. Before the onset of illness, the patient would consume 2–3 chapatis with cooked vegetables, pulses, and rice per meal. With the onset of illness, he started eating ½-1 Indian bread with some cooked vegetables in each meal for the initial few days. On being given food he would shove it away and sometimes start crying. Over the next 1–2 weeks, he stopped eating solid food. Over the last 2 weeks, the patient’s intake of solid food became bare minimum. He would only consume water, milk, and very dilute pulses. He refused any medications that were offered to him in solid form but would accept syrup formulations.

During this period the patient’s self-care also suffered significantly. He would have to be persuaded to brush his teeth and take a shower. His sleep was adequate during this period. There was significant impairment in his personal, social, and school life. The patient stopped going to school during this period and at home he spent most of the time in the room with his mother. He tried to study at home initially, as per his parents, but completely stopped studying for most part of the illness. He would occasionally involve in leisure activities like watching TV. He would interact with his siblings when they made an active effort but did not self-initiate conversations.

During the course of illness family members sought treatment from a physician. Initially the patient accepted medications but gradually over the course of illness he stopped accepting any medications. Family members also consulted an ENT specialist however no contributory medical problem for his symptoms could be found. As the patient was unmanageable at home, he was admitted to the Dept of Psychiatry King George’s Medical University (KGMU), Lucknow for detailed evaluation and management. Past history was non-contributory. Personal history indicative of delayed milestones and difficulty in learning simple tasks. Premorbid temperament revealed anxious traits in the child, he would never go to school alone (without his brother), when visiting a relative’s house, he would always stay close to his family members and never stay the night alone. At new places he would not go to the bathroom unaccompanied by his family members for the initial few days and liked to stick with known people and not initiate friendship with unknown people easily. On MSE affect was distressed, speech was decreased in volume as patient usually answers in short sentences of 1–2 words, and psychomotor activity was increased as the patient kept fidgeting during the interview and thinking revealed pre-occupation with the symptom. It was difficult to engage him during the assessment and definitive evidence for anxiety in thought content could not be elicited. Intelligence revealed poor general fund of knowledge and poor arithmetic ability. Insight was absent (Grade I).

On the basis of history and MSE, an unspecified diagnosis of anxiety disorder (F41.9) was kept. The patient was started on treatment Tab Mirtazapine 7.5 mg ½ BD And Syp A-Z 2tsf 1 OD. The patient showed significant improvement after 1 day, his appetite started improving, his interaction with family members improved, there was no episode of crying spell or breathlessness. He accepted the medications given to him with a lot of persuasions. He started eating rice and pulses in his meals after few days. Over the next several days, he started eating complete meals and asked for snacks in the evening. As the patient tolerated the medication well, the dose was increased to Tab Mirtazapine 7.5 mg 1BD. Seeing the response to treatment, an unspecified diagnosis of anxiety disorder (F41.9) was established. A psychological assessment was done to assessment. The patient was not cooperative on Vineland Social Maturity Scale (VSMS). According to the information given by the parents and his performance on GDT the patient’s score revealed SA/MA- 10years 6months, IQ/SQ-70-75, indicative of “Borderline” level of socio-adaptive functioning, but a reassessment was advised after 6 months. The patient was hospitalized for 1 more week, his ward behavior was observed and serial MSEs were done. The patient had no complains of dysphagia, breathlessness or crying spells during hospitalization. His appetite became adequate and interaction with family members was satisfactory. The patient was discharged after his recovery.

Discussion

Patients with intellectual disabilities have difficulty in expressing their psychological symptoms in words at times and present with atypical symptoms of the underlying disorder. This delays their diagnosis and appropriate management. Due to lack of
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reporting of psychological symptoms, the patient often continues seeking treatment from general practitioners, which leads to loss of time and money. Physicians and psychiatrists themselves need to be more watchful when evaluating a patient with an intellectual disability. Owing to the varied presentation and difficulty in identifying core disorders in these patients, some scales have been developed to evaluate psychiatric disorders specifically in intellectually disabled people like Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities/Mental Retardation [DC-LD].

Table 2: Scale available for different disorders in patients with intellectual disability

<table>
<thead>
<tr>
<th>S No.</th>
<th>Illness</th>
<th>Scale</th>
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<tbody>
<tr>
<td>1.</td>
<td>Schizophrenia</td>
<td>PAS-ADD*</td>
</tr>
<tr>
<td>2.</td>
<td>Depression</td>
<td>DC-LD* depressive episode criteria (9) PAS-ADD*</td>
</tr>
<tr>
<td>3.</td>
<td>Anxiety</td>
<td>Glasgow Anxiety Scale for People with Intellectual Disabilities (GAS-ID) (10) DC-LD anxiety disorder criteria (11)</td>
</tr>
</tbody>
</table>

*Psychiatric Assessment Schedule for Adults with Developmental Disability (PAS-ADD)
**Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities/Mental Retardation [DC-LD]

However, the awareness and application of these scales is still limited, and no formal criteria is present in our core diagnostic systems as of now. Hence to combat these problems, all clinicians need to be more vigilant. All doctors at the undergraduate level should be educated about the atypical clinical presentations of patients with ID so that more efficient referrals can be planned for these patients. Psychiatrists need to follow a combined strategy of detailed history taking, repeated interviews with family members, serial MSEs, vigilant observation of ward behavior and response to treatment to decipher the true nature of illness in a patient with intellectual disability.

REFERENCES