Clinical Guide To Assessment And Management Of Personality Disorders In The Adult Person With Mental Retardation And Developmental Disabilities (MR/DD)

Overview

The human personality is a complex composite of multiple intellectual functions including social skills, impulse control, affective modulation, risk assessment and ability to learn from past life experiences. Each intellectual process that contributes to personality is susceptible to alterations in persons with mental retardation. Affixing a diagnosis of a personality disorder implies that a patient is able to accurately self-assess interpersonal, social, legal and professional behavior as measured against a culturally established norm. Each of these capacities is vulnerable to deficits produced by specific aspects of mental retardation. This diagnosis requires a thorough understanding of the patient and their intellectual capacity.

Personality disorders are broadly divided into three categories, including Clusters A, B, and C **(See Table 1)**. Cluster-A features are predominantly centered on disruption of thought that includes peculiar ideas, magical thinking, and social isolation. Features of Cluster-B focus on poor impulse control and emotional instability. Cluster-C includes patients with a persistent pattern of social or professional withdrawal.

The rate of personality disorder within populations of normal intellect is estimated at 11% to 22%. The rates of personality disorders among persons with mental retardation are estimated as high as 23% or 31% **(See Table 2), (1)**. Personality disorders are generally diagnosed in individuals with mild retardation as the intellectual deficits identified in moderate to severely retarded persons are of such severity that personality is difficult to assess. Cluster A and Cluster B features predominate among the mentally ill **(1).**

Table 1

The Common Types of Personality Disorders with Symptoms and Pharmacologic Intervention

Cluster	Type	Major Symptom	Potential Pharmacological Therapy
A	Schizoid Schizotypal Paranoid	Disordered Thought	Antipsychotic Medications
B	Borderline Antisocial Narcissistic	Emotional Stability Impulse Control	Mood Stabilizers
C	Avoidant Passive Dependent	Withdrawal Dependency	None

Table 2

Distribution of Personality Disorders in Persons with DD/MR (2)

Cluster	Type	%
A	Paranoid	5
	Schizoid	10
B	Antisocial	3
	Histrionic	1
	Impulsive	7
C	Dependent	3

JIDR 1997;41(4):324-30

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Assessment of Personality Disorders

The assessment of personality disorders using standard testing instruments, such as the Minnesota Multiphasic Personality Inventory, in persons with mental retardation is limited by the patient's ability to comply with instruments such as the MMPI that involve hundreds of questions. Personality inventories contain internal tests to assess malingering that are based on the person's ability to recall or not recall other inventory items. Even the mildly retarded person has difficulties with managing complex instruments such as the MMPI.

Diagnosis of personality disorders requires a longitudinal assessment that measures whether dysfunctional behavior is the product of abnormal personality features in an otherwise intellectually capable individual or whether abnormal behavior is the reflection of stress and dysfunction produced by intellectual limitations. Published norms and standards for specific disorders are not available for persons with MR/DD and clinicians must resort to the standard of best possible judgment. The diagnosis of personality disorder in a person with mental retardation requires several key features for both the individual and the examiner. The person performing the assessment should have a detailed understanding of the person's longitudinal history and precise data on the types of behaviors that are being implied as a product of personality disorder. The examining clinician should have extensive experience in persons with mental retardation. A baseline evaluation should include an accurate assessment of intellect and communication skills. A precise diagnosis as to the cause of the patient's mental retardation is helpful, but not essential. The clinician should be provided with specific descriptions of behaviors or verbalizations that imply the presence of a personality disorder. For example, striking a peer as a result of impulsive behavior produced by post-concussive frontal lobe damage is distinct from a premeditated attack on another individual in retaliation for some event of the past. Impulsive, sexual touching is distinct from a premeditated sexual assault that occurs in the course of another criminal act, e.g., burglary.

The clinician should exclude a psychiatric or medical cause of the new onset of behaviors, attitudes, and interpersonal interaction that suggest a personality disorder. Depression, anxiety, psychosis, and substance abuse can produce many symptoms associated with Cluster B disorders. Medication side effects, pain, endocrine disorders, and seizures can also mimic these conditions.

Table 3

Personality Dysfunction and Disorders in Persons with MR/DD (2)

- 36-51% - some abnormality
- 22-31% - met criteria for disorder
- 70% - receive psychotropic medication

The diagnosis of personality disorder produces significant social and clinical ramifications for the patient. The overall prognosis of personality disorders is poor; especially in people with limited ability to develop insight. This diagnosis should be assigned by experienced clinicians with detailed understanding of the patient after a thorough examination and a precise definition of intellectual deficits.

Treatment

The treatment of personality disorders in the person with mentally retardation is complicated by the patient's limited ability to develop insight. Psychological and behavioral interventions are preferable to medications. Persons with mild MR/DD and borderline personality disorder may

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benefit from structured group psychological care with other individuals of normal intellect who experience similar difficulties. Suicidality, poor impulse control, and emotional lability are key therapeutic targets. Cluster B personality disorders may benefit from mood stabilizers and antidepressants based on clinical data from persons with normal intellect and similar diagnosis. Antisocial personality disorders are usually accountable to the criminal justice system (5).

Pharmacological interventions produce limited benefits for normal intellect individuals with personality disorders, inferring that medications have limited benefit to persons with intellectual disability and personality disorders. Individuals with personality disorder have high rates of psychiatric comorbidity including substance abuse, depression, and anxiety disorders. Specific psychiatric comorbidity may respond to psychopharmacology (1).

Conclusion

Personality disorders do occur in persons with DD/MR. This diagnosis is difficult to make and these patients are challenging to treat.

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