Book review

Psychiatric and Behavioral Disorders in Intellectual and Developmental Disabilities

Edited by Colin Hemmings and Nick Bouras
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When I was an SHO in general adult psychiatry and did not have exposure to people with intellectual disabilities (ID), I asked an expert in the field of psychiatry of ID in a conference, "How do you diagnose psychiatric disorder in a person with ID"? Three decades later after working with people with ID and their families, I am still looking for an answer to this question. Perhaps, I am asking the wrong question! As a Medic, I feel comfortable to put things into boxes, which sometimes helps me to justify using certain medication. But is this the right approach? Or should we look for an alternative approach to formulation to deal with issues in people with ID, which should lead to better management and subsequently help to improve quality of life of people with ID and their carers? These dilemmas and debates have been reflected in the book edited by Colin Hemmings and Nick Bouras. Dilemmas and debates are healthy – they lead to truth. Therefore, this text is much welcome. This is the third instalment of this prestigious textbook which stood the test of time.

The book starts with an excellent brief on the history of the subject written by Nick Bouras, which sets the scene for the rest of the text nicely. The chapter reflects Nick's wide experience and depth of wisdom. The book is nicely wrapped up by a personal reflection on the chapters of the book by Colin Hemmings. His reflection is at times controversial but always thought provoking and interesting to read. This proves the point that I have made earlier – debates and dilemmas are good – they lead to truth!

The book is conveniently presented in five distinct sections in order to cover every aspect of the topic. Section 1 is called "Foundations", which sets the scene for the rest of the book. This section includes apart from Nick Bouras's contribution on "historical and international perspective" as discussed before, chapters on classification and diagnosis by Marco O. Bertelli, Luis Salvador-Carulla and James Harris, the epidemiology of psychiatric disorders in adults with ID by Jason Buckles and assessment instruments and rating scales by Heidi Hermans.

Section 2 covers various aspects of mental disorders in the context of ID with an emphasis on adults. This section includes chapters on dementias by Jennifer Torr, schizophrenia spectrum disorders by Rory Sheehan, Lucy Fodor-Wynne and Angela Hassiotis, mood disorders by Anna M. Palucka, Pushpal Desarkar and Yona Lunsky, anxiety disorders by Jane McCarthy and Eddie Chaplin, stress, traumatic and bereavement reactions by Philip Dodd and Fionnuala Kelly, personality disorders by late William R. Lindsay and Regi Alexander, mental illness with ID and autism spectrum disorders by Trine L. Bakken, Sissel B. Helvershou, Siv Helene Høidal and Herald Martinsen and attention deficit/hyperactivity disorder by Elizabeth Evans and Julian Trollor.

Section 3 covers various aspects of interventions including chapters on psychopharmacology by Stephen Ruedrich, psychodynamic psychotherapy by Nigel Beail, cognitive-behavioural therapy by Dave Dagnan and behavioural approaches by Betsy A. Benson.

Section 4 covers special topics such as chapters on psychopathology of children with ID by Bruce Tonge, behavioural phenotypes/genetic syndromes by Robert M. Hodapp, Nathan A. Dankner and Elisabeth M. Dykens, offending behaviour by John L. Taylor and late William R. Lindsay, problem behaviours and interface with psychiatric disorders by Sally-Ann Cooper, the interface between medical and psychiatric disorders by Jessica A. Hellings and Seema Jain and epilepsy by Frank M.C. Besag.

Section 5 covers important issues relating to services in which chapters are written on specialised and mainstream mental health services by Johanna Lake, Carly McMorris and Yona Lunsky, service users' and carers'

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experiences of mental health services by Katrina Scior and carer and family perspectives by Gemma L. Unwin, Shoumitro Deb and John Rose.

Two issues, namely, case detection and case definition always cause problem for any epidemiological study. Prevalence studies of mental disorders in people with ID are no exception. How do you capture all people with ID (particularly those who are at the milder end of the spectrum) in the population in order to draw a valid conclusion about the right prevalence? How do you diagnose psychiatric disorder in a person with severe and profound ID? Is it possible to use the same definition and framework across the board for people with mild ID and also with severe and profound ID? Do you include problem behaviour, ASD, ADHD and other neurodevelopmental disorders within the definition of a psychiatric diagnosis? This is why perhaps it is not surprising to see such a wide variation in the prevalence figures quoted in published studies.

The vexed issue of the overlap between a psychiatric diagnosis and problem (challenging) behaviour is also addressed in the book. It seems that both over-diagnosis and under-diagnosis are possible in this context. However, it is worth reminding the readers that problem behaviours in general and aggression in particular are present not only in people with ID but also in many neuropsychiatric disorders (in the absence of a psychiatric diagnosis) such as acquired brain injury, epilepsy, neurocognitive disorders (dementias), cerebrovascular disorders, acute confusional state as well as in drug and alcohol misuse and in many neurodevelopmental disorders such as ASD and ADHD (Deb and Deb, 2016). Therefore, it is not clear whether problem behaviours in general and aggressive behaviour in particular is a symptom or a behaviour or a syndrome or a psychiatric disorder? This dilemma is reflected in the fact that the conduct disorder, intermittent explosive disorder and oppositional defiant disorder (closest diagnoses for problem behaviours) are defined in the *DSM5* in such a way that they are at best difficult and at worst impossible to apply to many people with ID (Deb *et al.*, 2016).

The issue of how to define ID has also come up in the text. Should this be based on IQ alone or a wider variety of cognitive assessment and social functioning? How do you define personality disorders in people with ID? Is what we call a problem (challenging) behaviour in people with severe ID, often called a personality disorder when it occurs in people with mild ID? The text reflects the growing interest in neurodevelopmental disorders such as ASD and ADHD and their overlap with ID. As a result both *DSM5* and proposed ICD-11 have now put them under one umbrella of "Neurodevelopmental disorders".

The use of psychotropic medication for the treatment of problem behaviours in the absence of a diagnosed psychiatric disorder in people with ID is controversial as the evidence base to support their use is thin (Deb, 2016). However, non-pharmacological interventions are gradually making their way into ID, which is a welcome sign, although the evidence base for their effectiveness is no better than that for pharmacological interventions (Hassiotis and Hall, 2009). It is heartening to see that the all-important and yet often ignored issue of carers and families have been specifically covered in this book.

I recommend this book to all professionals who work with people with ID as well as to the carers and family members of people with ID.

Shoumitro Deb

Shoumitro Deb is based at Department of Medicine, Division of Brain Sciences, Imperial College London, London, UK.

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