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Manic-Depressive Psychosis in a Mentally Handicapped Person: Diagnosis and Management

The diagnosis of manic-depressive psychosis in mentally handicapped people can be easily overlooked, partly because its presentation differs from that in people with normal intelligence. This report illustrates some of the difficulties involved in making the diagnosis of manic-depressive psychosis in a mentally handicapped person and in planning for her future care.

The coexistence of mental illness and mental handicap poses a considerable diagnostic challenge. Nevertheless, identification and management of any existing psychiatric disorder is important, because such disorders compound difficulties in adjustment and put extra pressure on the carers. Until recently, some writers considered exclusion of mental handicap as a prerequisite for the diagnosis of mental illness (Schneider, 1959; Winokur, 1974). It has been established now that mentally handicapped people have an increased vulnerability to psychotic disturbances (Eaton & Menolascino, 1982). However, the diagnosis of manic-depressive psychosis in a mentally handicapped person is a difficult one and can be easily missed.

Pollock (1945) examined the psychiatric diagnoses of 444 mentally handicapped people admitted for the first time to New York State Hospital between July 1941 and June 1942, and found seven cases (1.6%) of manic-depressive psychosis. Reid (1972) found that the incidence of manic-depressive psychosis in a hospitalised population of mentally handicapped people was 4.4%. Heaton-Ward (1977) reviewed the case notes of 484 mentally handicapped hospitalised patients; ten (2%) were given the diagnosis of manic-depressive psychosis.

Once the diagnosis of manic-depressive psychosis is established, treatment with lithium may prove to be helpful. Naylor *et al* (1974) showed significant reduction in the duration of illness in a two-year double-blind crossover study, using lithium to treat 14 mentally handicapped people with manic-depressive psychosis. Rivinus & Harmatz (1979), in a single-blind placebo controlled study, showed significant improvement in all the symptoms of affective disorder and also a reduction in the number of relapses. Phenothiazines and butyrophenones are amongst other suggested treatments.

This paper reports a case of manic-depressive psychosis which presented over the years as schizophrenia, and which has responded to treatment with lithium carbonate.

Case Report

AC is now in her early sixties. She has lived in a psychiatric hospital for the past 13 years. She went to the same school as her brother and sister, but stayed one year longer because she was found to be 'backward'. Her birth and childhood were otherwise normal.

After leaving school at the age of 15, she started work in a local factory. At 18, she found it difficult to cope with the job, and complained that the men at work were teasing her. At the same time, there were air raids, which upset her. She was admitted to a psychiatric hospital in an excitable, noisy state. There, she was found to be manneristic, laughing, emotional, and crying. A diagnosis of schizophrenia was made and she was treated with insulin and ECT. She was noted to be moderately mentally handicapped. She stayed in hospital for two years; a year after discharge, she was readmitted with a history of weight loss and poor sleep. This admission may have been precipitated by the death of an old friend; she stayed for a year, again recovering with insulin therapy and ECT. She was described as a clean, tidy person with a shy and sensitive personality.

When AC was 48, her father was admitted to hospital for a significant physical illness. Her mother had died some 4 years earlier, and she was unable to support herself alone. By this time, she had more than 12 admissions to psychiatric hospitals and had spent nearly 15 years as an in-patient. Between admissions, she had lived happily with her parents, attending an adult training centre and regularly visiting a psychiatric out-patient clinic.

Admission was then arranged in a mental handicap hospital on a permanent basis. She initially appeared to settle, but about two years after admission, she became excitable, restless, and hostile, laughing incessantly, talking to herself and to God with marked pressure of speech. She became disinhibited, wandered naked, demanded attention, and smoked heavily. She also neglected herself, lost weight, slept poorly, and was incontinent. This behaviour lasted for several months, followed by a period of two weeks, when she was quiet and able to take care of herself. Staff commented at this time that she was pleasant and likeable. Episodes of such disturbed behaviour recurred during the following twelve years. On some occasions, she was transferred briefly to a psychiatric hospital, where she received ECT without lasting improvement. Large doses of phenothiazines and butyrophenones were given; she was

also put on benperidol for her disinhibited behaviour, but she continued to be difficult to manage.

Her history and mental state were then reviewed. The cyclical nature of the heightened mood in the setting of a well preserved personality and a relatively good premorbid adjustment were suggestive of manic-depressive psychosis, and this diagnosis was further supported by the positive family history—in the past, her mother had been admitted to a psychiatric hospital with affective disorder.

On 600 mg of lithium per day, she attained therapeutic plasma lithium levels, her mood stabilised, she became co-operative, pleasant, amenable, involved in ward and occupational therapy activities. Considerable improvement in sleep, appetite, and concentration was noted. Her relationships with others, her communication skills, and personal hygiene improved remarkably; she gained in self-esteem and her smoking was reduced. She began to be liked by both staff and other residents. For the first time since admission, her sister requested permission to take her home for a weekend. Both her sister and brother-in-law noticed the change in her, and enjoyed the three days of companionship.

Ten months later, she remained on lithium and had only one mild manic episode which lasted for 2 to 3 weeks, brought under control by adding thioridazine, 25 mg b.d. to the treatment regime. It is anticipated that A C will continue to take lithium for at least two years, under the care of a psychiatrist with an interest in mental handicap.

Discussion

It has been demonstrated that among the non-mentally handicapped population, many individuals subsequently diagnosed as suffering from mania have previously been thought to have schizophrenia (Carlson & Goodwin, 1973; Taylor & Abrams, 1973; Tyrer & Shopsin, 1982). This misdiagnosis may be more common in mental handicap, due to under-reporting of depressive or manic symptoms by carers (Hasan & Mooney, 1979).

In retrospect, AC exhibited several symptoms of mania on her first and subsequent admissions, but her elation was poorly sustained and lacked an infectious quality. Hallucinations and delusions were simple and naive, lacking wit and humour, in keeping with Reid's (1972) observations on mentally handicapped people with mania. It seems likely that her limited vocabulary and intellectual level were modifying the presentation of her psychopathology.

She may be discharged to community facilities, but if community-based mental handicap services are to be successful and to function efficiently, then early identification and efficient treatment of psychiatric disorders are vital; this is clearly the role of the psychiatrist (Bicknell, 1985; Heaton-Ward, 1977). Better training for nurses in the fields of clinical psychiatry and psychopharmacology and encouragement for psychiatrists to maintain their diagnostic and treatment skills are essential in the interests of better mental health for mentally handicapped people.

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