Chapter 10
Psychopathology in People with Epilepsy and Intellectual Disabilities

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Introduction

Psychopathology refers to the manifestation of behaviors or experiences that may be indicative of mental illness or psychological impairment. The term is broad, encompassing all phenomena that might, but might not, reach significance for a psychiatric diagnosis. As a result, the debate about the occurrence of psychopathology in people with epilepsy has been long and intense. If behavior is the manifest aspect of psychic life, then aberrations of behavior are usually attributed to some form of abnormal mental state; there can be no doubt that this is a significant issue in people with epilepsy. There is further difficulty in interpreting psychopathology or behavioral disorders in people with intellectual disabilities (ID), particularly in people with severe ID. How, then, do we understand the issues surrounding psychopathology in people with ID and epilepsy?

In this chapter we will seek to look at these issues in more detail, describing findings in people with ID without epilepsy, in the general population with epilepsy, and then, where possible, looking for ID-specific research in the field of epilepsy.

Psychopathology in Intellectual Disability

Accurate measurement of psychopathology in any population can be difficult, but is made more difficult in people with ID because of methodological challenges. There is a need to define, appropriately, the terms to be used in research and this is especially important in this area.

In declaring an ID there is a need to, first and foremost, define the term. In most literature there is now agreement that ID is crudely defined by a significantly reduced ability to understand new or complex information, or to learn new skills, impaired intelligence (IQ below 70), and a reduced ability to manage independently (impaired social function), with onset in the developmental period (before the age of 18 years). Using this definition, between 2% and 3% of the general population...
will have ID, however, when epidemiological samples are collected, they seldom achieve more than a 0.5% ascertainment rate. The most likely reason for this is that most registers are based on the individual requiring a service (healthcare or social care) and therefore miss out on the majority who do not require, or are unaware of, services. Most research in the field of ID therefore suffers from a sampling bias due to the nature of case ascertainment with an overrepresentation of people with more significant ID and a requirement for additional assistance. Because those people with mild ID are in contact with services, they are more likely to have a higher rate of psychopathology.

Defining psychopathology can be even more difficult than defining ID. Diagnostic and assessment tools should be applicable to people with ID. The World Health Organization’s *International Classification of Diseases, Tenth Edition* (ICD-10)\(^3\) and the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV)\(^4\) were designed for use in the general population. They rely on the subjective reporting of symptoms, and people with ID often do not recognize or cannot report their own symptoms. In addition, caregivers may not realize the significance of symptoms or overreport normal phenomena in people with ID. The Diagnostic Criteria for Adults with Learning Disability (DC-LD) attempts to address this issue.\(^5\)

When the literature is reviewed, there is little consensus in terms of what may or may not be included. The terminology covered by the psychopathology rubric includes mental illness, mental disorder, psychiatric illness, psychiatric disorder, emotional problems, and behavioral problems. Some authors use the broad definitions in ICD-10, DSM-IV, or DC-LD, while others wish to exclude behavior disorders and personality disorders when defining their research question. Often this will leave the reader pondering the research criteria and wondering whether the sample population presented represents the patients they see in clinical practice. Further difficulties arise when authors use a battery of assessment tools in order to define “caseness.” These tools are not always comparable and seldom have relevance in a purely clinical setting, making it difficult for clinicians to apply the research to their practice. In addition, the method used for assessing psychopathology must be considered, as different prevalence rates can be found in the same

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Rate in ID(%)</th>
<th>Rate in General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Bipolar affective disorder</td>
<td>1.5%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Depression</td>
<td>4%</td>
<td>3–7%</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>1.5%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>2.5%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Autism</td>
<td>7%</td>
<td>0.08%</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>30%</td>
<td>1%</td>
</tr>
</tbody>
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