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Interviewing Techniques for Patients with Intellectual Disability

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Abstract

Communication is the foundation of every relationship. How individuals perceive their connection with their mental healthcare provider significantly influences the success of their treatment relationship. Interviewing patients with Intellectual disability (ID) can be a challenge due to patient factors such as limited communication abilities and difficulty sustaining attention and concentration. Physician related factors that may pose a challenge include limited experience treating patients with ID resulting in a lack of confidence as well as managed care restrictions such as limited time. Recognizing these factors and gaining experience in treating these individuals are the best ways to overcome these challenges. When evaluating an individual with ID, it is essential to gather collateral information. If the patient gives consent, it is helpful to have someone such as a caregiver, family member, or other invested party present for the interview, as they are able to provide valuable, objective information. It is important to speak directly to the patient during the interview, even if they are nonverbal or if you are obtaining information from a third party during the interview.

Keywords: Intellectual disability, Developmental disability, Interview techniques, Nonverbal patients

Levels of Intellectual Disability and Categories of Communicative Skills

When conducting a patient interview, it is crucial to understand the individuals' level of ID as well as their expressive language skills in order to communicate effectively. Review of intelligence testing and adaptive skill deficits is critical to achieve an understanding of dependency needs and how the patient navigates the community. It is important to note that most individuals with ID have better receptive than they do expressive language skills. Though they may have limited verbal skills, they typically still understand what is being said during the interview.

Challenges in the Diagnostic Assessment of Psychiatric Disorders in Individuals with Intellectual Disability

*There are four difficulties in interviewing and assessing an individual with ID that are related to developmental delay and/or cognitive limitations [2]. Individuals with ID may display behaviors typical of early development throughout their adult life. Among the general population, these difficulties would be considered typical in a young child but abnormal in an adult. Egocentrism is an example; this is the tendency for an individual to construe reality in

Table 1: Levels and communication.

Level	Communication
Mild ID	• Verbal • Uses concrete terms
Moderate ID	• Verbal • May answer questions with monosyllabic or other short responses
Severe or profound ID	• Significantly limited verbal communicative abilities

Table 2: Categories of communicative skills (adapted from Hassiotis et al. [1]).

Category of Communicative skills	Description
Preverbal	• Does not have cognitive ability to understand words • Typically have profound and multiple learning disabilities • Can be assisted through the use of routines, tone of voice, repetition, context of situations, objects and their own experience
Nonverbal	• Has ability to understand words, but does not have the ability to express themselves using words • Will use alternative means to communicate, e.g. use of signing or pictures
Verbal	• Has a variety of skills for understanding language • Has expressive capabilities, and predominantly uses speech

a way that is based only on what the individual experiences [1]. Egocentrism is related to the cognitive capacities seen in very young children and is sometimes is confused with narcissism. Preschool-aged children often fail to comprehend that others may see or experience things differently. Individuals with ID also may have similar difficulty understanding the impact of their behavior on others due to cognitive limitations, and sometimes their conduct is incorrectly interpreted as oppositional behavior or a manifestation of narcissistic psychopathology when it really is a manifestation of their developmental level.

Some of the behaviors typical of early development but that may persist into adulthood for persons with ID may include self-talk, imaginary friends, and fantasy play. It is important to note that these behaviors may be within normal limits for the individual's level of development, and may not necessitate treatment [3].

Table 3: Diagnostic challenges.

Difficulties	**Definition**	**Example**
Cognitive disintegration	Impaired ability to tolerate stress leading to anxiety-induced decompensation that can lead the individual to appear bizarre, psychotic, or somatic.	Patient with ID who recently moved to a new group home starts reporting a new imaginary friend. This could be considered normal behavior for ID though it may be considered bizarre for an individual in the general population.
Psychosocial masking	Limited life experiences, social skills, and intellectual capacity can influence the content of psychiatric symptoms. These symptoms may be easily missed because they might seem normal for a neurotypical individual in the general population.	Manic patient with moderate ID who believes he has a girlfriend and is able to drive a car. Though driving a car and being in a relationship is common for an individual in the general population, this may be a delusion of grandeur for a patient with ID.
Intellectual distortion	Diminished abstract thinking and communication skills limit the ability of the person to accurately and fully describe emotional and behavioral symptoms	Patient with ID may answer "Yes" when the clinician asks if they hear voices. The clinician was referring to auditory hallucinations while the individual was referring to ordinary voices such as the physician's.
Baseline exaggeration	Pre-existing maladaptive behavior not attributed to a mental illness may increase in frequency or intensity with the onset of a psychiatric disorder	Patient with ID with aggression at baseline which can be controlled with behavioral techniques suddenly presents with increased aggression during a manic episode.

Building Rapport

It is widely accepted among those in the medical community that a strong therapeutic alliance is essential to patient care and can have an effect on patient satisfaction, quality of life, and treatment outcomes. As with treating patients in the general population, it is important for the physician and the individual with ID to work collaboratively. In order to make the patient feel comfortable, it is beneficial to begin the interview by asking general, non-threatening questions such as their favorite activities, foods, or about their work or living arrangements. This also allows the physician to assess the patient's communication skills in a non-threatening manner.

Clinical Pearls for Interviewing Individuals with Intellectual Disability

- Be respectful.
- Match questions and answers to the individual's level of expressive language.
- Ask permission to involve collateral data sources.
- Collect collateral information and manage the triangle (See Chapter 2).
- Know what to expect. When possible, review all available medical records prior to the evaluation.
- Use simple language.
- Concretize the abstract.
- Use alternative ways to communicate when necessary (e.g. pictures, drawings).
- Ask the individual to repeat something if you did not understand what was said.
- Take responsibility for miscommunication.
- Eliminate distractions and unnecessary noise/ movements during the interview.
- Do not use slang or figurative speech.
- Allow more time and consider multiple meetings if needed.
- Recap and summarize what occurred during the evaluation.

Interviewing/Evaluation of the Nonverbal Patient and Non-verbal Communication across All Patient Populations

Across all specialties, physicians are trained to rely heavily on verbal communication, making the evaluation of the non-verbal patient particularly challenging. However, 60–65% of all interpersonal communication among individuals in the general population is conveyed via nonverbal behaviors [4]. Having a better understanding of nonverbal communication can improve a physician's understanding of all patients regardless of their expressive language ability.

Table 4: Examples of nonverbal behaviors as diagnostic criteria for common psychiatric disorders (Adapted from APA, [5]).

Disorder	Nonverbal behaviors
Autism spectrum disorders	Marked impairment in eye-to-eye gaze, facial expression, body postures and gestures; stereotyped, repetitive motor mannerisms.
Attention-deficit/hyperactivity disorder	Does not appear to listen when spoken to; easily distractible; fidgeting; inability to remain seated or attend to conversation
Substance intoxication or withdrawal	Cannabis intoxication: Conjunctival injection Opiate intoxication: Miosis Opiate withdrawal: lacrimation, rhinorrhea, yawning
Major depressive disorder	Psychomotor agitation or retardation; restricted or blunted, dysphoric affect; tearfulness
Post traumatic stress disorder	Hypervigilance; exaggerated startle response; restricted range of affect
Schizophrenia	Flat affect, poor eye contact, avolition (negative symptoms); disheveled appearance, unpredictable agitation, rigid or bizarre postures (grossly disorganized or catatonic behaviors)

Table 5: Universal facial expressions of emotion (Ekman et al. [6]).

Surprise	• Jaw drops • Opening the mouth without tension • Eyes open widely • Raised brows • Forehead wrinkles horizontally throughout
Fear	• Lips tense, stretch and draw back • Eyes open with lower lid tense and upper lid raised • Brows raised, drawn close together • Forehead wrinkles horizontally in the center only
Disgust	• Upper lip raises and nose wrinkles • Lower eyelid moves upward • Brows are lowered
Anger	• Lips tightly closed • Eyelids tense • Brows are lowered and drawn close together • Wrinkling appears vertically between the brows
Happiness	• Corners of lips draw upward and nasolabial folds become prominent • Lower eyelid raises and wrinkles appear around eyes
Sadness	• Lips tremble or corners draw downward • Eyes may tear • Inner brows raise and draw together

Cultural Humility in Interviewing Persons with ID

Culture is 'a system of shared beliefs, values, customs, behaviors, and artifacts that members of society used to cope with their worlds in with one another.' Culture is threaded throughout family structure and is inherently passed on through the generations [7]. Communication affects our verbal as well as nonverbal expressive language. Culture is fundamental to all of our internal and external experiences and most importantly how we navigate relationships [7]. It is important for the clinician to be aware of his or her own cultural background as well as be familiar with the culture of their patients. We can learn the general principles of other cultures but should never make assumptions about any individuals based on their cultural background. The interviewer should have the ability to alter their own communication style based on the needs of the patient.

Understanding an individual's cultural or ethnic background plays a significant role in connecting with patients and in building rapport. Being aware of personal space, gestures, eye contact, or broaching sensitive topics are all handled very differently depending on the culture, as alluded to previously. Jackson [7] states that 'Cultural competence values diversity with the goal to manage the dynamics of difference.' This transcends accommodating assistive devices or providing an interpreter when indicated; it speaks to respecting the individual with the reverence that he or she deserves (Developmental Disabilities and Bill of Rights Act 2000). It is a commitment to hear the patient's story on their terms.

Understanding and being cognizant of one's own culture is important because of the tendency to regard one's own cultural group as the standard to which all others are compared [7]. It is vital to learn about the people you serve. The process resembles psychotherapy in some respects; the effectiveness of a psychotherapist will increase with the level of their self-awareness.

The effective interviewer will communicate with persons with ID in a professional, thoughtful, and nonjudgmental manner [7]. Nonverbal communication includes factors such as facial expressions, gestures, personal distance,

sense of time, and seating arrangements. Some elements of communication transcend across various cultures, while other nonverbal communication holds vastly different meanings from one geographical area to the next. Jackson [7] illustrates this concept by pointing out that a smile in some cultures simply means that they heard you, while in other cultures it denotes agreement. In Western culture, direct eye contact is viewed as a positive communication skill. Eye contact in certain Asian and Hispanic cultures is not appropriate. Making the gesture 'okay' by forming a circle with your thumb and forefinger with the remaining three fingers extended means 'okay' in the United Kingdom and the USA. In Japan it indicates money. In Brazil it is an insult. In Russia it means zero [7].

Personal space varies from culture to culture and some individuals with ID may be unaware of this concept due to limited socialization in the community and/or a limited number of individuals in their social support system. The seating arrangement and angle of the chairs is essential; the ability of the individual to make eye contact with the interviewer on the same level is essential [7]. In a person with Fragile X Syndrome, to sit directly facing them will increase anxiety and decrease eye contact. Cultures vary in standards for gender, loudness of speech, speed of delivery, silence, attentiveness, timing of when to enter a conversation, and decision-making [7]. The effective clinician is aware of these concepts.

Summary

The best way to get experience is to get experience. Educate yourself by interviewing as many individuals with ID as possible. This not only increases your experiential knowledge base but also your confidence and comfort level. Be a detective and investigate the core issue. Be aware of the commonalities within each category of ID and study the principles of the developmental framework of the patient, while keeping in mind that each person is an individual with a unique personality. Be honest when you do not understand the individual's speech or communication; feel free to ask the individual to repeat the response or to enlist the assistance of a collateral source in the room when appropriate. When discussing intimate or sensitive topics, keep in mind that you can always request one on one time with the individual.

Be respectful of all assistive devices and treat as these devices as if they are part of the individual's personal space. Attend to a patient's individual communication style or format. With regard to question types, remember that the high-yield accurate information will most likely be gained from use of pictorial multiple-choice and factual yes/no questions, closely followed by subjective yes / no questions. Question types that tend to be lower yield (although individually dependent on the person with ID) include either/or questions, followed by the least consistent which are verbal multiple-choice and open-ended questions. It is always worthwhile to add either focused or general open-ended questions in the mix whether or not they are answered accurately; these can still provide the interviewer with new insight and valuable information. Remember to recap, summarize, clarify and paraphrase. Above all, establish an alliance with the patient. When you're able to collect important diagnostic data from the patient while making them feel at ease, there is more potential to accurately diagnose. Each individual with ID, whether verbal or nonverbal, has an important story to tell.

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