Behind the Diagnosis:

Frailty in Learning Disabilities Through Clinical Cases

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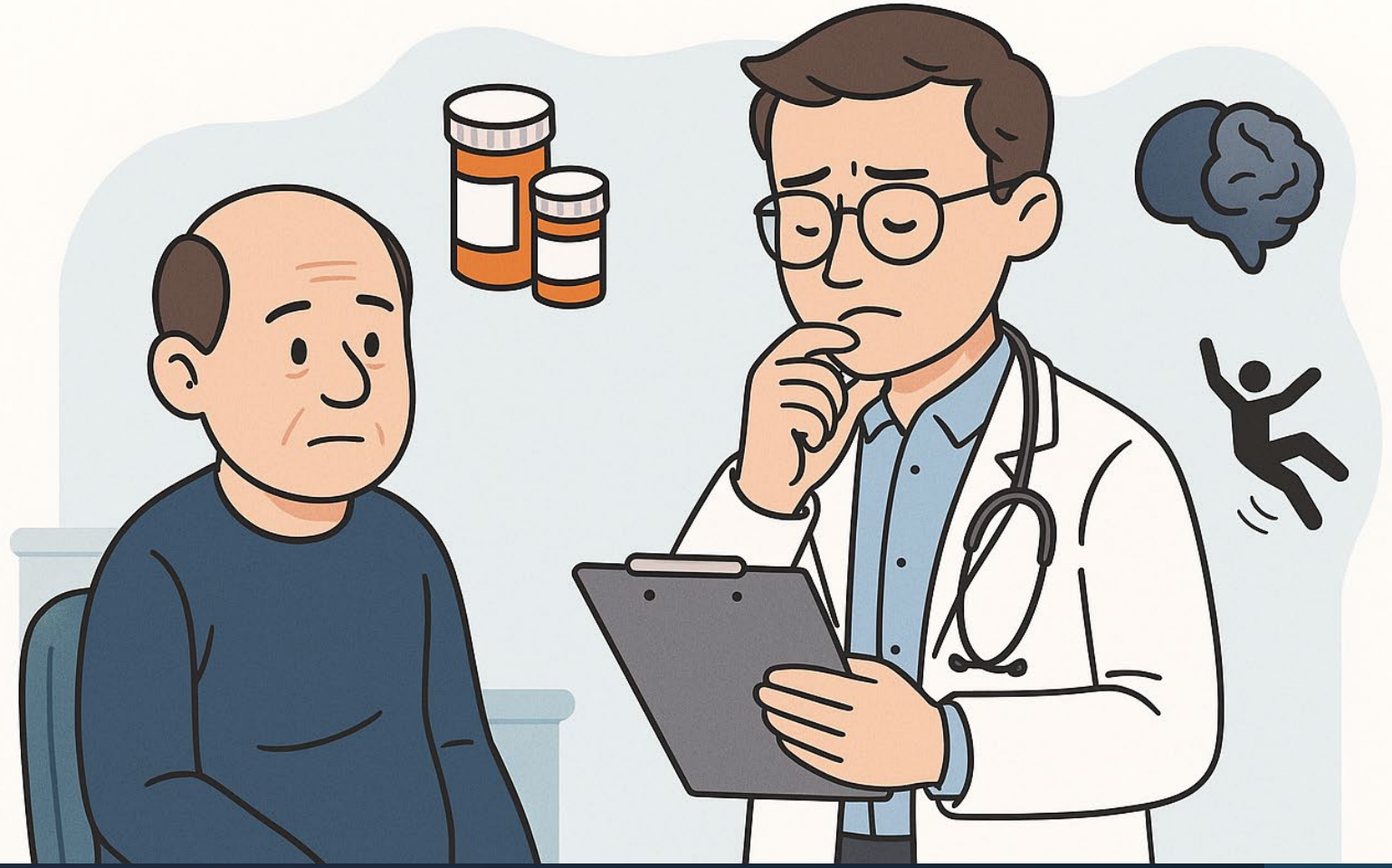
Overview of the presentation

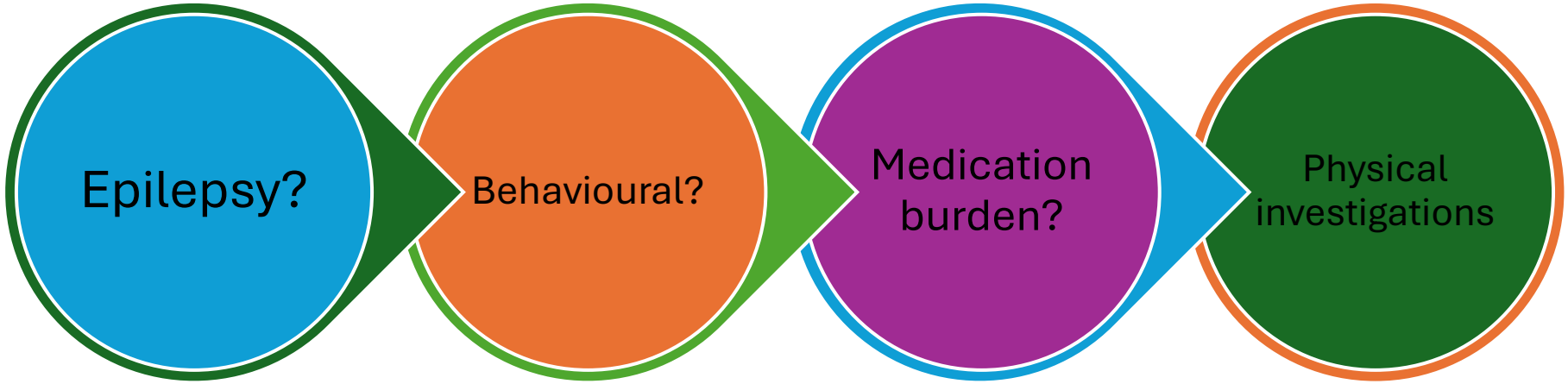
- Case examples
- Diagnostic heuristics and decision making
- Recognising frailty in Learning disabilities
- Overcoming the challenges
- Key Takeaways

The Falling Puzzle: Avoiding Diagnostic Pitfalls

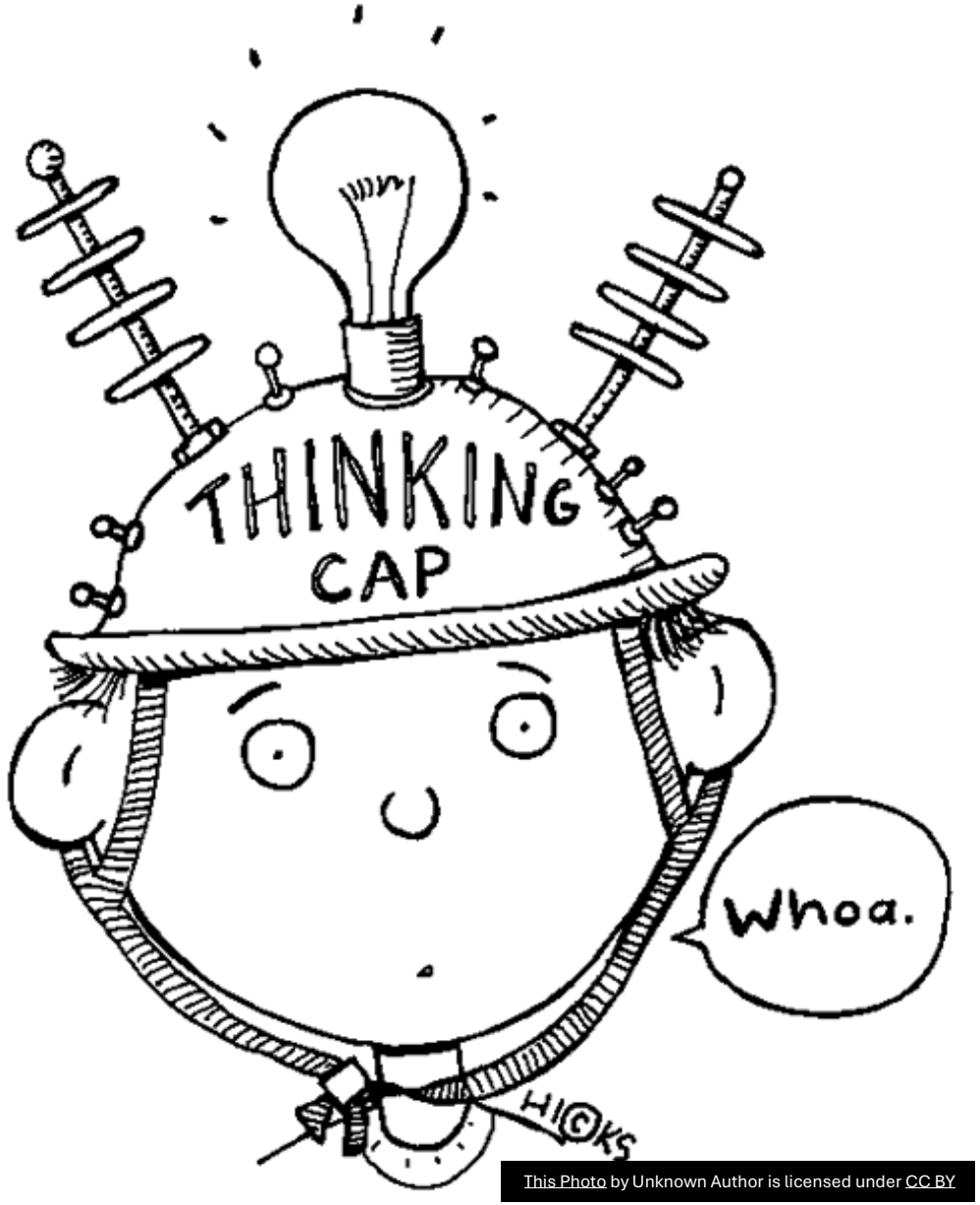


Case 1

- John is a 55-year-old non-verbal man with severe learning disabilities and challenging behaviour. Over recent months, his caregivers have noticed a steady increase in the number of falls.
- He has a history of **epilepsy (in remission)** and **hypothyroidism**, and is prescribed **multiple psychotropic medications** to manage behaviour.


Epilepsy?
Behavioural?
Medication burden?
Physical investigations

- He stops eating and starts to lose weight
- Mobility continues to decline – he cannot get up from bed without 2 people supporting him
- Family and carers concerned..



The Silent Change – Sally's Story

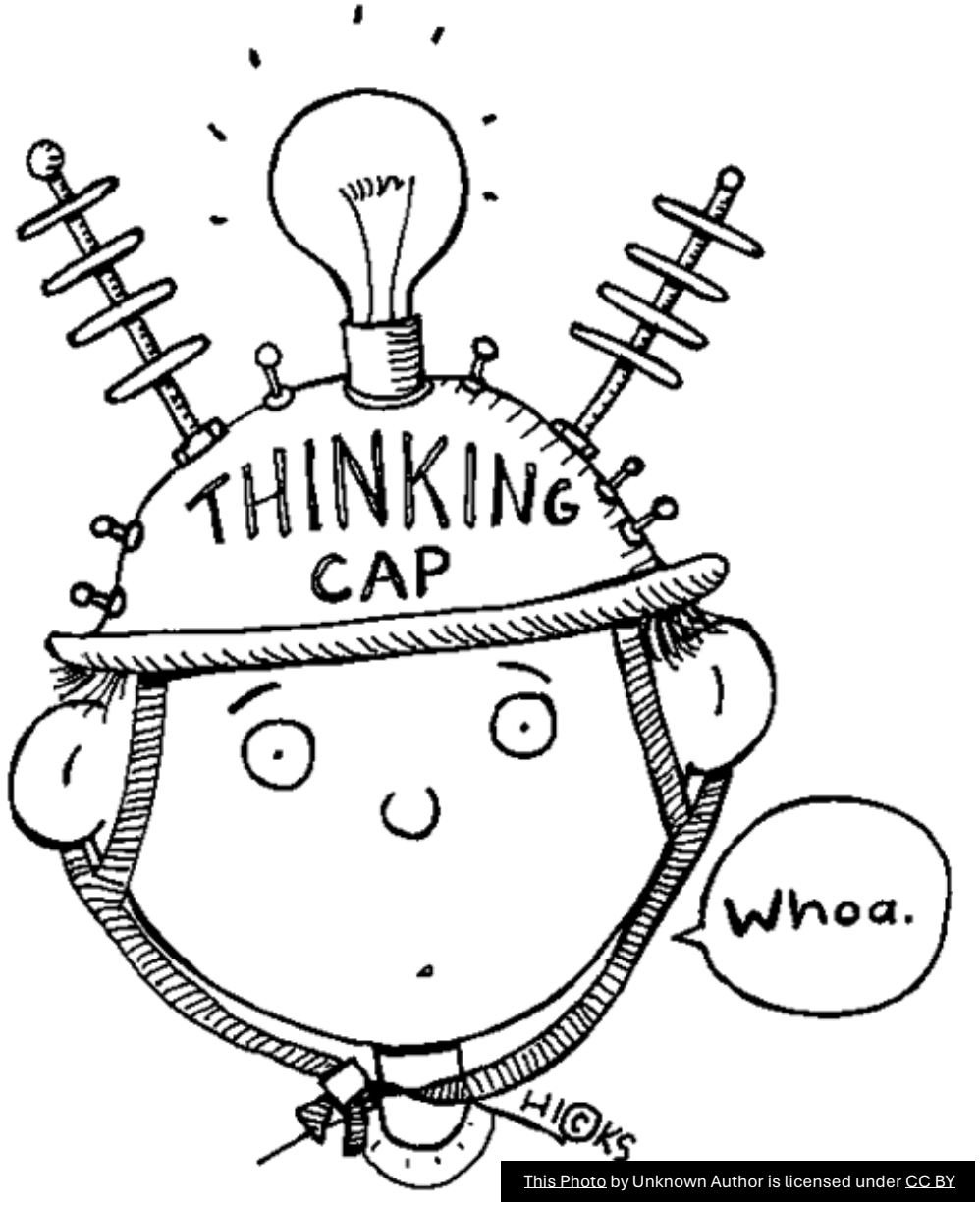
Case 2

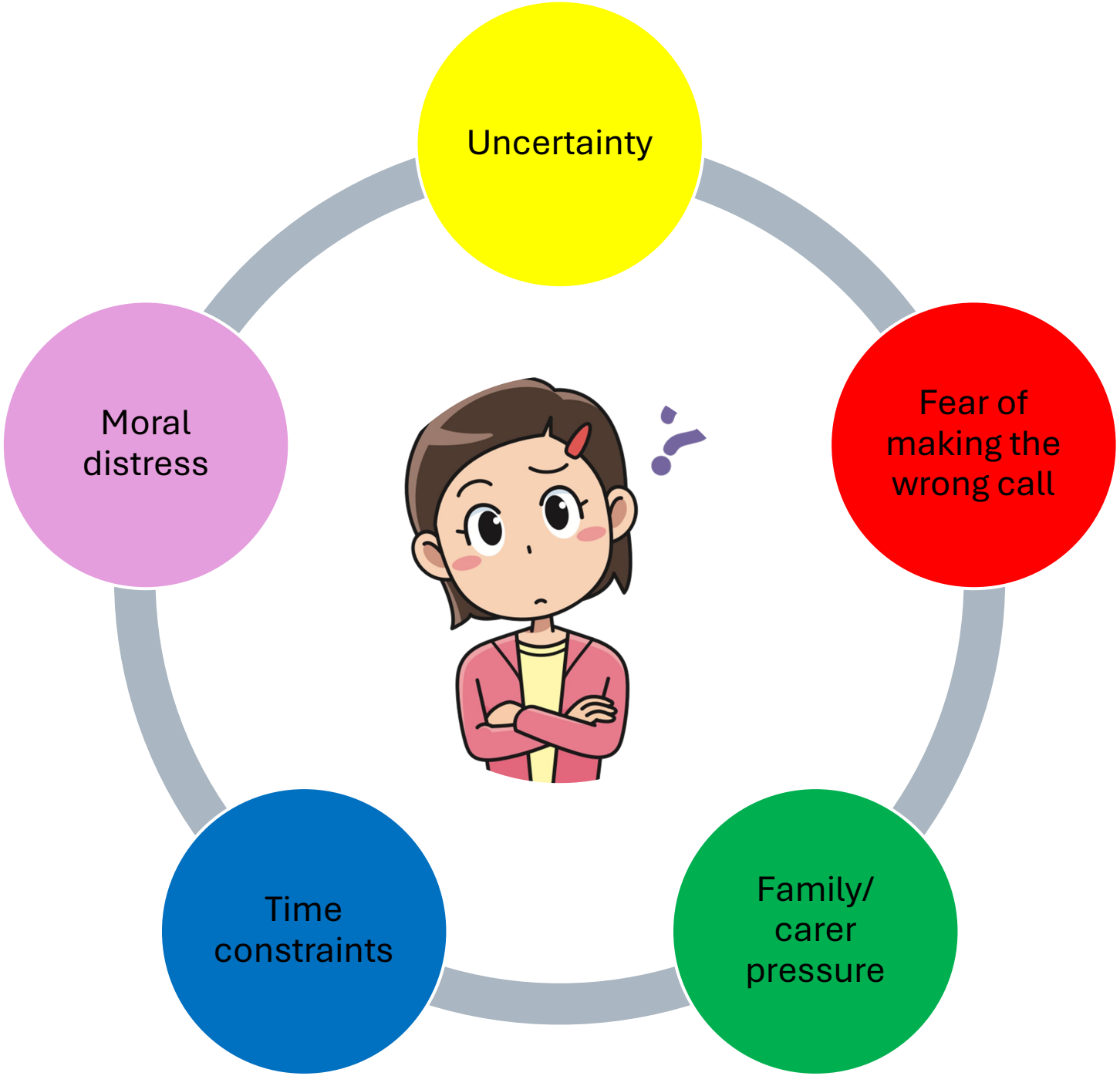
- Sally is a 43-year-old woman with **Down syndrome** and **moderate intellectual disability**.
- Over the past three months, she has become noticeably more anxious, with **frequent meltdowns** disrupting her daily activities.
- Sleep apnoea
- 10 years back she was started on fluoxetine for her anxiety and she responded well up to now

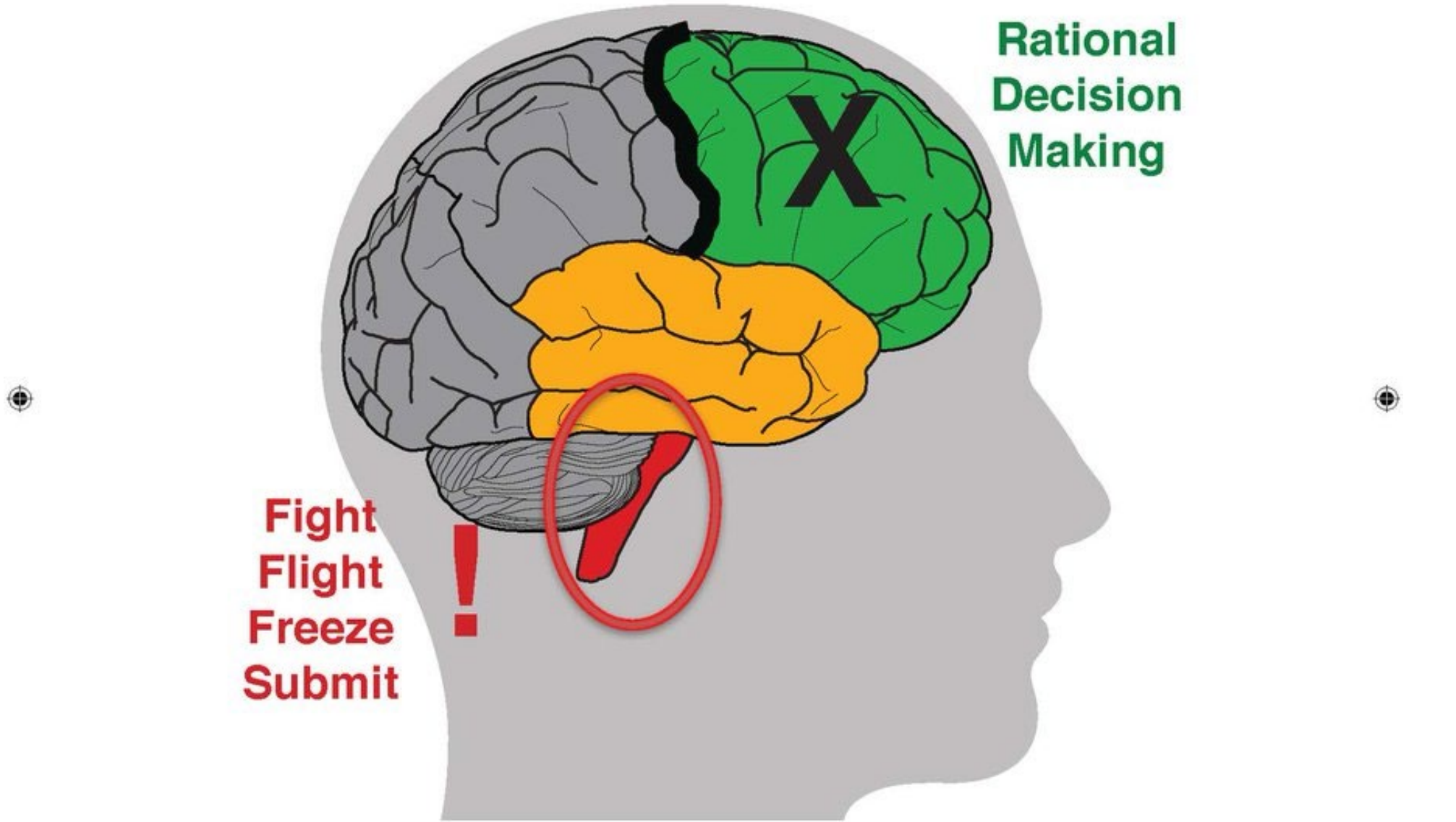
- Worsening of anxiety – why?
- Tried to increase her fluoxetine dose – started leaning to a side and gait now broad based and unsteady
- Sensitive to medication side effects..
- Tried changing anti anxiety medication – no improvement

- Worsening of her mobility, Sally now **leans forward when walking**, worsening of unsteadiness and her **broad-based gait**, and her **walking distance has gradually reduced**.
- Meltdowns getting worse – she cannot access respite due to anxieties – carers getting burnt out.
- Unable to do investigations without sedation

- No improvement in anxiety – developed **new-onset seizures**.

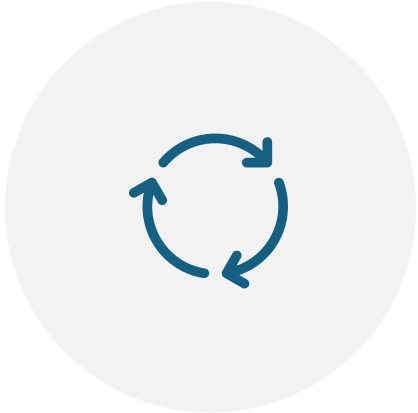



Uncertainty
Fear of making the wrong call
Family/ carer pressure
Time constraints
Moral distress


Rational
Decision
Making
X
Fight
Flight
Freeze
Submit
!

Impact on Clinical decision making

Response	How It Might Manifest	Impact on Clinical Decisions
Fight	Arguing forcefully for one course of action, dismissing colleagues' views, overconfidence	Can lead to **rigid or biased decisions**, missing nuanced aspects of LD/frailty care
Flight	Avoiding the decision, deferring to others, delaying intervention	May result in **inaction or neglect**, especially for vulnerable patients needing timely care
Freeze	Feeling overwhelmed, unable to decide, focusing excessively on details	Can cause **analysis paralysis**, missed opportunities, or lack of clear communication with the team/family



PROCESS LESS INFORMATION.

LESS LIKELY TO NOTICE SUBTLE CHANGES.

MORE LIKELY TO RELY ON OUR BIASES.

Heuristic Errors / cognitive errors

- Representation error
- Availability error
- Anchoring error
- Confirmation bias
- Search satisfying
- Diagnosis momentum
- Commision bias
- Affective heuristic
- Playing the odds
- Fundamental attribution error

Confirmation Bias:

- Are we seeing what we expect to see?

Polypharmacy & Adverse Effects:
- Could treatment be part of the problem?

Diagnostic Overshadowing:
- Are we missing anything organic or treatable behind the behavioural?

Heuristic	Strength	Weakness
Representativeness	Quick diagnosis, action through pattern recognition	Non-prototypical variants may be missed
Availability	Events that come to mind easily are common and should therefore be considered	Events that do not come quickly to mind are not considered
Anchoring	First impressions often give valuable information	It is difficult to move from incorrect first impressions
Confirmation bias	None	Can compound the failure to adjust from initial impressions (anchoring)
Search satisfying	Saves the time and effort of a search for comorbidity, as often none exists	Comorbidity, which is particularly common in psychiatry, is missed
Diagnosis momentum	None	Inaccurate diagnostic labels persist, potentially resulting in incorrect treatment and stigma
Commission bias	Avoids omission bias; optimal information is not always available in the real world	Adverse effects of unjustified treatment may violate the ethic of *primo non nocere*
Affective heuristic	Clinicians should be sympathetic towards patients	Unpleasant diagnoses or interventions may not be adequately considered
Playing the odds	Assumption of benign diagnosis or positive outcome is usually correct	Negative diagnoses or outcome may not be adequately considered
Fundamental attribution error	Not applicable	Patients may be inappropriately blamed and judged, to the detriment of their care

Why is Frailty in LD complex?


Atypical
Multiple comorbidities
Existing vulnerabilities
Faster Aging
Diagnostic overshadowing
Communication barriers
Frailty in LD

- In patients with learning disabilities, new behaviour may be the language of underlying disease.

What might we be missing?

Maths !

- Start by adding 12 and 8 to get your first total. Multiply that result by 3, then subtract 10. Divide the new number by 2, and keep that answer in mind. Next, take the digits of that number, reverse them, and add 5. From that sum, subtract the number of letters in your first name. Multiply what you have left by 4, then add 25. Take half of that amount, round it to the nearest whole number, and multiply it by 25 and add 100 to the total. I just wanted to see who would read the instructions to the end so no need to do this calculation, take a deep breath, smile, and stand up when you read this.

What should we do next?

THINK

REVIEW

COLLABORATE

Slowing down

Widening perspective

Prevents premature closure in complex patients

How do we break this cycle?

- Pause – slow down – reframe
- Working hypothesis and differentials- write down why you think this is this
- Don’t mix up vulnerability factors,trigger factors with current
- Be aware of our bias
- MDT input and collateral information
- See the full picture

Key Takeaway

- Frailty in learning disabilities is often missed because it doesn’t fit our usual patterns.
- Heuristics and stress are powerful — and unavoidable — but we can train ourselves to recognize their influence.
- By slowing down, reflecting, and listening to the full picture, we can catch frailty earlier — and change outcomes for some of the most vulnerable people in our care.

Resources

- How psychiatrists think | Advances in Psychiatric Treatment | Cambridge Core


RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

advances
in psychiatric treatment

journal of continuing professional development

How psychiatrists think

Niall Crumlish and Brendan D. Kelly
APT 2009, 15:72-79.
Access the most recent version at DOI: 10.1192/apt.bp.107.005298


THANK YOU!