Summary
Psychopathology is a frequently found co-morbidity in people with intellectual disabilities (ID). To fully understand the pathways of psychopathology in young people with ID, longitudinal research studying predictors from childhood into adulthood is required. Chapter 1, attended the developmental psychological perspective, needed to understand regular developmental processes, and life-events and circumstances that influence these developmental processes. Also, the relationship between intellectual disabilities, psychopathology, and associated factors was elucidated. In this dissertation the population consisted of a large representative sample of Dutch schoolchildren, initially aged 6-18 years, with ID. These children/adolescent were followed for a period of five years, hence making this a longitudinal study. Data was collected at three separate phases from parents, teachers and the children participating at least at one of the three phases. The aims of this study were: (1a) To what extent is the developmental course of behavioural and emotional problems in children and adolescents different from their course in childhood and adolescence from the general population? (1b) What is the prevalence of psychiatric problems in adolescents and young adults with mild and moderate ID? How does this relate to age and level of ID? (2a) To what extent is level of ID related to developmental change in behavioural and emotional problems? (2b) To what extent are changes in child and family factors related to developmental change? (2c) What are the most promising factors regarding potential reduction in psychiatric outcomes?

In Chapter 2, we compared the developmental course of psychopathology in children and adolescents with and without ID. We described similarities and differences between the two populations, including gender differences for various types of emotional and behavioural problems. Children with ID showed a higher level of problem behaviours across all ages compared to children without ID. Results indicated that children with ID continued to show a greater risk for psychopathology compared to typically developing children, although this higher risk was less pronounced at age 18 than it was at age six for aggressive behaviour and attention problems. Contrary to our expectations, the developmental course of psychopathology in children with ID was quite similar from age 6 to 18 compared to children without ID. It was concluded that the normative developmental trajectories of psychopathology in children with ID presented in this Chapter could serve as a yardstick against which development of childhood psychopathology can be detected as deviant.
In Chapter 3, we compared development of emotional and behavioural problems in children with mild versus moderate ID as reported by parents and teachers. Developmental course, stability, persistence and onset of emotional and behavioural problems were presented. Almost 25% of the children had deviant levels of emotional and behavioural problems. For most types of problem behaviour youths with mild ID and moderate ID showed similar levels of stability of individual differences, persistence, and onset of psychopathology. Whenever differences were found, youths with moderate ID showed the highest level of stability, persistence, and onset across informants. Mean levels of parent-reported, but not teacher-reported, problem behaviour, regardless of level of ID, decreased during the 5 year follow-up period. It was concluded that youths with moderate ID and mild ID were to similar degrees at risk for persistent psychopathology. Different informants showed to have a different evaluation of the level and the amount of change of problem behaviour, and were considered to be complementary in the diagnostic process.

In Chapter 4, we focussed on the aetiology of psychological problems. Associations between changes in the level of psychological problems and changes in child, family and environmental factors were determined. Youths who showed a larger than average decrease in problem behaviours, also were more likely to show declines in physical symptoms, (larger) increases in adaptive behaviour, and their parents showed declines in level of psychopathology. Increasing communication skills, decreasing physical problems, improving family functioning, and experiencing negative life events strengthened these reciprocal associations. It was concluded that the course of problem behaviour in children with intellectual disabilities is associated with changes in child, family, and environmental factors. Also, clinicians and caretakers should be especially aware of the influences of changes in child physical health and parental mental health on the changes in psychological well-being of the child. Findings from this study point to variable factors that should be tested for their causality in future studies, and which are interesting targets for intervention.

In Chapter 5, childhood child/adolescent, family and environmental risk indicators for psychiatric disorders in adolescence and young adulthood were identified, as well as risk profiles that could be used in preventive strategies. Results showed that deviant levels of internalising and externalising problems, inadequate adaptive behaviour, and parental psychopathology predicted psychiatric disorder. Almost 30% of the young people with ID met the criteria for a psychiatric disorder. Also it was found that children/adolescents exposed to multiple risk indicators were at greater risk to
develop psychiatric disorders. It was concluded that strategies aiming risk reduction of psychiatric disorder in children/adolescents with any level of ID should focus on intervening at an early age, improving psychopathology and adaptive behaviour skills of the children/adolescents, and supporting their parents, especially in those who encountered multiple risks.

In the final Chapter, Chapter 6, the main findings and conclusions were discussed, and recommendations for future studies and clinical implications were given. It became clear that maturing from childhood into young adulthood, emotional and behavioural problems diminish in most young people with ID. However, when unattended, these children with ID are at risk for developing psychiatric problems during and after adolescence. In order to be able to prevent psychiatric disorders in this group it is necessary to focus on all the different areas (e.g., limited adaptive skills, parental psychopathology and experiencing negative life events) in which these children experience negative influences instead of on one single problem at the time. Parents, caregivers, teachers and health care professionals should work together in monitoring young people with ID. Concerning treatment, four conclusions were drawn; first, prevention should start at an early age, when the first symptoms of emotional and behavioural problems appear. Second, adaptive skills of the children should be improved, to improve their resources to face the challenges of life. Third, when parents experience mental health problems or intellectual disability themselves, they will have fewer resources to raise and support their child, and therefore these parents need support. Treating the parents for their own mental health problems should be part of the treatment package for the children and adolescents. Finally, regular treatment methods with minor adjustments (e.g., minimising and simplifying verbal information, adding visual components, doing instead of talking, short sessions, more sessions, practising in real-life situations) should be used in treating psychopathology in young people with borderline to moderate ID. Health insurance companies, government and policymakers should facilitate healthcare providers in developing and providing effective treatment methods for this specific group. The issue was raised that young people with ID who develop disruptive disorders such as vandalism, aggression and delinquency, take a toll on society as well. The long-term effects and costs of treatment for society should be investigated, including decreasing criminality levels, and not just the short term costs of single treatments.