**A Comparison of Intelligence Quotient in Children with and without β-Thalassemia Major**

Samaneh Homayouni Meymandi1, Seyed Hamid Seyednezhad-Golkhatmi2, Mandana Homayouni meymandi3

1. Corresponding Author, Msc of clinical psychology, Department of psychology, Zahedan University of Medical Sciences. Zahedan. Iran.
2. Msc of Clinical psychology, Department of psychology, Zahedan University of Medical Sciences, Zahedan, Iran.
3. Msc of Clinical psychology, Department of psychology, Shiraz University, Shiraz, Iran.

**Background and Aims:** Thalassemia is the most common hemoglobinopathy worldwide. Children with β-thalassemia major have several risk factors for cognitive problems. The aim of this study is to evaluate intelligence quotient in children with β-thalassemia major and healthy counterparts using Wechsler Intelligence Scale.

**Materials/Subjects and Methods:** Within a cross-sectional design and using convenience sampling method, the present study was carried out in Zahedan and Shiraz in 2012. Participants were matched based on age, gender and city of residence (40 children with β-thalassemia major and 40 healthy children aging from 6 to 12). Wechsler Intelligence Scale Revised (WISC-R) was used to find the participants, Verbal, Performance and Full intelligence scores. The scores of the two groups were then compared using descriptive analysis and independent t-test.

**Results:** As compared to their healthy counterparts, children with β-thalassemia major had lower scores on both Verbal Scale and Full Scale (p<0.01); However, the difference of the two groups’ scores on Performance Scale fell short of significance.

**Conclusion:** Cognitive decline does not necessarily occur in children with β-thalassemia. They are just slightly lower than their healthy counterparts and they need to receive more attention in in education in order to improve.

**Keywords**: thalassemia, β-thalassemia, Intelligence Quotient, cognitive function, children

**Introduction:**

Thalassemia is the most common hereditary hemoglobinopathy worldwide and a major problem in our society and in many other countries [1-4]. Beta-thalassemia is the most common type of thalassemia and occurs in three forms: thalassemia minor, thalassemia intermedia, and thalassemia major in which the child suffers from severe anemia, and if not treated with blood, the disease will lead to heart failure and death in early childhood. During the first few months of life, β-thalassemia major which is often diagnosed at childhood shows itself as decrease in fetal hemoglobin levels and increase in iron deposition in the blood [4-7]. In children with β-thalassemia major, iron overload is the main cause of disorders in various organs [8]. Iron accumulation damages tissues at the end of the first decade of life and a set of symptoms appears including impaired growth, hypothyroidism, adrenal insufficiency, cardiac and hepatic complications, hypoxemia, cognitive disorders in the central nervous system, and long-term brain injuries. Several studies examined the brain of thalassemic patients and reported higher iron deposition in their putamen, caudate nucleus, and motor and temporal cortices [9-13]. In addition to pain and discomfort related to treatment complications, awareness of difference with other children may adversely affect the mood of school-age thalassemic children whose need for ongoing medical care may result in frequent absences from school and weakening of school performance [14-15]. Hereditary cognitive disorders in children are described with clinical syndromes, chromosomal defects, metabolic disorders, or nerve damage. These disorders are divided into change in short-term memory and mediation of long-term memory and may have negative effects on growth of individuals’ cognitive and critical processes regarding environmental experiences and social interactions [16]. Due to iron overload in their brain, children with β-thalassemia are more likely to have disorders in their Central Nervous System; therefore, timely diagnosis along with adequate treatment for problems in their Central Nervous System are critical to improving their intelligence and cognitive functions [12-13]. According to Piaget’s theory of cognitive development and assuming that biological principles governing the individuals’ physical activity and growth can be also applied to the mental activity and growth, intellectual development follows a certain pattern and qualitative differences exist in the classification of cognition in thinking of children of all ages. In this theory, intelligence is thought as an adaptive process which requires a balance between organism and environment. Also, novel cognitive constructs and abilities, which require general factors emanating from social life, grow in accordance with growth and aging [17].In the literature, there are few studies on the Verbal, Performance and Full intelligence of children with β-thalassemia and healthy counterparts as a part of their cognitive perception; and the findings are generally contradictory and ambiguous. A number of the studies suggest that Thalassemia causes cognitive disorders but other studies found that this disease has no impact on cognition or if there is any, it is very limited [13-14 , 18-21]. Based on the effect of thalassemia on the body and Central Nervous System and its crucial role on forming the person’s thought and attention to the environment, the present study seeks to compare children with β-thalassemia major and normal counterparts in Verbal, Performance, and Full intelligence quotients (IQs). While the areas of strengths and weaknesses of these children are identified, appropriate educational and rehabilitation strategies can be suggested.

**Materials and Method:**

Within a cross-sectional design and through convenience sampling method, the present study was carried out in 2012. According to Nevruz *et. Al* [16] and Duman *et al* [14], the sample size was estimated 40 participants in each group. 20 children with β-thalassemia major were selected from Ali Asghar Hospital in Zahedan and 20 children with β-thalassemia major were selected from Dastgheyb Hospital in Shiraz. The control group included 40 healthy children without any blood disease, selected out of four elementary schools in each city through convenience sampling method. They were then matched with the experimental group based on age, gender and city of residence. In each group, participants were categorized into four subgroups according to their gender and city of residence. In β-thalassemia major group, 20 children were selected from Zahedan (10 girls, 10 boys) and 20 children were selected from Shiraz (10 girls, 10 boys). Similarly, in healthy children group, 20 children were selected from Zahedan (10 girls, 10 boys) and 20 children from Shiraz (10 girls, 10 boys). All the participants aged between 6 and 12. Children in β-thalassemia major group were receiving blood once a month regularly, and they were taking deferoxamine as medication. After having the participants’ consent and following medical ethics, all the participants were assessed physically, psychologically and intellectually in two separate sessions in order to have research conditions under control. In the first session, Mini Mental Status Interview (MMSI)[[1]](#footnote-1) was performed by the researcher and nothing that might cause poor performance on the test (i.e. psychiatric disorder such as mood and anxiety disorders, physical disorders like neurological ones, alcohol or drug abuse, head trauma or medication) was observed in the participants. The interview was done in the hospital with the experimental group and at school with the control group. In the second session, Wechsler Intelligence Scale Revised (WISC-R), which is made for children aging from 6 to 13, was administered in order to find the Intelligence Quotient (IQ) of the two groups.

**Wechsler Intelligence Scale Revised (WISC-R):** This test assesses the intelligence of children in three scales of Full IQ, Verbal IQ, and Performance IQ using 6 Verbal Subscales (including Information, Digit Span, Vocabulary, Arithmetic, Comprehension, and Similarities) and 6 Performance Subscales (including Picture Completion, Picture Arrangement, Block Design, Object Assembly, Symbol Search, and Mazes), totally 12 subscales. Classification of intelligence into two main Verbal and Performance types is due to its diagnostic value and not due to existence of two different intelligence types.Verbal Scale of WISC-R IQ test includes 6 subtests or subscales as follows: (1) Information Subtest with 30 questions which measures the child’s information and depends highly on the child’s culture as well as his formal and informal education, (2) Digit Span Subtest with two parts: to repeat sequences of numbers either as heard or in reverse order, (3) Vocabulary Subtest with 32 items identifying the child’s cognitive abilities, memory, information span, and verbal reasoning, (4) Arithmetic Subtest with 18 questions on simple calculations, (5) Comprehension Subtest with 17 questions which measure the child’s understanding of social issues, and (6) Similarities Subtest with 17 items which measures the child’s understanding of how two words are alike or similar. Similarly, Performance Scale includes 6 subtests or subscales as follows: (1) Picture Completion in which the child is shown artwork of common objects with an important missing part, and asked to identify the missing part, (2) Picture arrangement with 12 items. Each item consists of 3 to 5 cards containing pictures that are placed in front of the child in an incorrect order; the child must rearrange the pictures to tell the intended story within a limited time, both accuracy and speed are scored, (3) Block Design Subtest in which children put together red-and-white blocks in a pattern according to a printed red-and-white model. This subtest is also timed, (4) Object Assembly Subtest including four items, each item being a cut up object, like a puzzle. The child must correctly assemble the parts of the puzzle in a limited time, (5) Symbol Search Subtest with two forms: form A for children under 8 age in which they mark rows of shapes with different lines according to a code, and form B for children over 8 age in which they transcribe a digit-symbol code. This task is also time-limited, (6) Mazes Subtest with 11 square mazes presented to the child. The child must find the way out of the maze and draw lines in the time given. During 1982-1985, the test was translated into Farsi in Shiraz University and its psychometric properties were reported. Eleven tests out of twelve (except Vocabulary test) were translated into Farsi and those questions improper for Persian culture were identified and substituted with suitable equivalents after preliminary survey. However, the test instruction, the time for each subtest, and scoring of responses did not change. Instead of mental age, deviated IQ was used to calculate intelligence quotients (IQs) of Wechsler scale. Raw scores of the WISC-R subtests (the scores given to the items according to the participant’s response) were converted to subtest scaled scores by referring to a table of score equivalents appropriate for the examinee’s age. Then, with a 4-month difference from each other, Verbal, Performance and Full IQs of each age group were found with a mean of 100 and standard deviation of 15. The reliability of tests and IQs was calculated using the methods of test-retest and split-half; the median reliability coefficient of this test was 0.73. The correlation coefficient of subtests with each other and with Verbal, Performance, and Full IQs was used as the standard measure of validity [22-23].

Statistical calculations were done on the scores of the two groups and data were analyzed using SPSS-18 software. The results and goals were analyzed using descriptive tables and independent t-test.

**Results:**

In the present study all the participants were elementary school students, and aged between 6 and 12 years old. The mean and standard deviation of the age of children with β-thalassemia major was 9.57±1.33 and that of the healthy children was 9.5 ±1.31. Table 1 presents characteristics of the two groups according to gender and city of residence. Based on the results of WISC-R; the mean Verbal IQ in children with β-thalassemia and their normal counterparts were 96.27 ± 6.71 and 104.42 ± 6.38, respectively; the mean Performance IQ in children with β-thalassemia and their normal counterparts were 105.10 ± 4.80 and 105.40 ± 4.80, respectively; and the mean Full IQ in children with β-thalassemia and their normal counterparts were 101.27 ± 6.08 and 105.70 ± 5.65, respectively. Table 2 presents the mean, standard deviation, *t*-test results, and the significance level of Performance difference between children with and without β-thalassemia major in Wechsler subscales. As can be seen, there was no significant difference between the two groups in terms of Similarities, Vocabulary, and Block Design Subscales, while the performance of β-thalassemic children was significantly lower than that of healthy group in terms of Information, Arithmetic, Comprehension, Digit Span, Picture Completion, Symbol Search, and Mazes Subscales (*p*<0.01). However, children with β-thalassemia performed better than healthy children on Picture Arrangement (*p*<0.01) and Object Assembly (*p*<0.05). Furthermore, comparison of Verbal, Performance, and Full IQs between the two groups revealed that Verbal and Full IQs in β-thalassemic children were significantly lower than those of healthy children (*p*<0.01), but no significant difference was seen in their Performance IQ.

**Discussion:**

The present study assessed the intelligence quotient of children with β-thalassemia major and healthy counterparts in terms of Full, Verbal and Performance Scales of IQ using 12 subscales of Wechsler IQ test for children. Results indicated that children with β-thalassemia major had lower performances in Full and Verbal IQs (*p*<0.01). But, according to mean scores of the two groups and Wechsler’s views on IQ classifications, this downfall is not necessarily considered as serious. However the two groups didn’t perform significantly different on the Performance subscales. In his research on 7-15 years old , Duman (2011) reported that children with β-thalassemia major have lower scores than the control group in Full, Verbal and Performance scales of WISC-R test [19]. These findings are not consistent with the results of the present study about lower performance of children with β-thalassemia on the Performance Scale. Economou (2006), investigated the IQ of children with β-thalassemia major using WISC III and reported that these children have higher scores in Verbal Scale than Full and Performance Scales, and suggested that β-thalassemia potentially increases deficits in cognitive performance [14]. These findings about higher Verbal scale scores are also inconsistent with the results of the present study. In another study, the IQ of neurologically intact adults with sickle cell anemia was assessed by Vichinsky (2010) using WAIS III and it was reported that they had lower scores on Full, Verbal and Performance Scales of the test than the control group. These findings are consistent with the present study in terms of Verbal and Full intelligence but inconsistent in terms of Performance Scale[20]. Using WISC-III, Zafeiriou *et al*. concluded that sickle cell thalassemia does not necessarily endanger cognitive function of patients [21].  Karimi (2006) assessed IQ of β-thalassemia major patients and their healthy peers through Raven test and concluded that β-thalassemia major patients did not differ from their peers in IQ. These findings are in contrast with the results of the present study and other similar studies [18]. The type of test used as the tool for cognitive evaluation by Karimi *et al*. can be one reason of different findings[25]. Canatan *et al*. conducted a research in Antalya on psychosocial burden of β-thalassemia major, and reported that academic problems were found in 60% of sample population of thalassemic children [24]. These problems indicate that there is insufficient attention to the quality of education of these children. Regarding this study and previous ones, and bearing in mind that in children with β-thalassemia major Verbal IQ score -which depends highly on education, linguistic and communication skills as well as general physical health- is dropped, it is suggested that children with β-thalassemia major need to receive more academic attention in order to improve their IQ. However, as the children with β-thalassemia did not perform significantly different from healthy counterparts on the Performance Scale, it is put that these children do not need specific formal training for Performance IQ and can have a normal and successful life through interaction and adjustment with environment and common factors of social life; Therefore those children with valuable experience in social interactions are less likely to be damaged in this area [14-15, 17]. However, due to their illness, children with β-thalassemia major are more likely to have disorders in their Central Nervous System and timely diagnosis along with adequate treatment for problems in their Central Nervous System are critical to improving their intelligence and cognitive functions. Most of the studies suggest that Anemia can lead to hypoxia, iron deposition, and long term brain injuries in people with thalassemia; However, there are few studies on brain impairments in the literature and the reported findings are generally contradictory [13-14, 18-21]. Contradictions can be due to assessment tools, the extent to which the illness has affected body, social environment, the extent to which the patient is supported, and primary individual differences. Metaferati (2001) confirmed the statements on the effect of thalassemia on the Central Nervous System by reporting higher iron deposition in putamen, caudate nucleus, and motor and temporal cortices of thalassemic patients [13]. β-thalassemia major is often diagnosed in childhood and the treatment starts at the same time, however unpleasant and long regimens used, along with their increased life expectancy and prognosis in middle age, put patients and their families at risk for physical, emotional, and behavioral problems [7]. That’s why Pakbaz (2005) suggested that it’s necessary to pay careful attention to the needs and life problems of patients with thalassemia and their families [25].

**Conclusion:**

These findings suggest that in addition to the impact of disease on the patients’ perception mechanisms, other factors such as primary learning situations, and the impact of life experiences and individual differences on the way they respond to their environment- are also possible determinants of how these patients perform differently from healthy control groups; Furthermore, their IQ would improve if children with β-thalassemia major receive adequate training for increasing their apprehension and awareness. Therefore, considering several limitations of this study, and relying just on primary biographic information and IQ assessment, the results should be interpreted and generalized with caution. Limitations include: not having considered the age of treatment initiation and the amount of iron deposition in different brain parts, and not having other cognitive parts such as Learning Disorders and academic improvements measured. It is suggested to carry out more research in this area considering the mentioned limitations.

**References:**

1. Kiani AA, Mortazavi Y, Zeinali S, Shirkhani Y. The molecular analysis of beta-thalassemia mutations in Lorestan Province, Iran. Hemoglobin. 2007;31(3):343-9.

2. Rund D, Rachmilewitz E. Beta-thalassemia. N Engl J Med. 2005 Sep 15;353(11):1135-46.

3. Kutlar F. Diagnostic approach to hemoglobinopathies. Hemoglobin. 2007;31(2):243-50.

4. Rezaee AR, Banoei MM, Khalili E, Houshmand M. Beta-Thalassemia in Iran: new insight into the role of genetic admixture and migration. ScientificWorldJournal. 2012;2012:635183.

5. Galanello R, Origa R. Beta-thalassemia. Orphanet J Rare Dis. 2010;5:11.

6. Taher AT, Otrock ZK, Uthman I, Cappellini MD. Thalassemia and hypercoagulability. Blood Rev. 2008 Sep;22(5):283-92.

7. Monastero R, Monastero G, Ciaccio C, Padovani A, Camarda R. Cognitive deficits in beta-thalassemia major. Acta Neurol Scand. 2000 Sep;102(3):162-8.

8. Atiq M, Bana M, Ahmed US, Bano S, Yousuf M, Fadoo Z, et al. Cardiac disease in beta-thalassaemia major: Is it reversible? Singapore Med J. 2006 Aug;47(8):693-6.

9. Chen SH, Liang DC, Lin HC, Cheng SY, Chen LJ, Liu HC. Auditory and visual toxicity during deferoxamine therapy in transfusion-dependent patients. J Pediatr Hematol Oncol. 2005 Dec;27(12):651-3.

10. Moayeri H, Oloomi Z. Prevalence of growth and puberty failure with respect to growth hormone and gonadotropins secretion in beta-thalassemia major. Arch Iran Med. 2006 Oct;9(4):329-34.

11. Wong V, Li A, Lee AC. Neurophysiologic study of beta-thalassemia patients. J Child Neurol. 1993 Oct;8(4):330-5.

12. Incorpora G, Di Gregorio F, Romeo MA, Pavone P, Trifiletti RR, Parano E. Focal neurological deficits in children with beta-thalassemia major. Neuropediatrics. 1999 Feb;30(1):45-8.

13. Metafratzi Z, Argyropoulou MI, Kiortsis DN, Tsampoulas C, Chaliassos N, Efremidis SC. T(2) relaxation rate of basal ganglia and cortex in patients with beta-thalassaemia major. Br J Radiol. 2001 May;74(881):407-10.

14. Economou M, Zafeiriou DI, Kontopoulos E, Gompakis N, Koussi A, Perifanis V, et al. Neurophysiologic and intellectual evaluation of beta-thalassemia patients. Brain Dev. 2006 Jan;28(1):14-8.

15. Zafeiriou DI, Economou M, Athanasiou-Metaxa M. Neurological complications in beta-thalassemia. Brain Dev. 2006 Sep;28(8):477-81.

16. Johnston MV, Alemi L, Harum KH. Learning, memory, and transcription factors. Pediatr Res. 2003 Mar;53(3):369-74.

17. Naidenova X. J. Piaget’s theory of intelligence: operational aspect. Computer Science Journal of Moldova. 2001;9, no.2(26):208-30.

18. Karimi M, Yarmohammadi H, Cappellini MD. Analysis of intelligence quotient in patients with homozygous beta-thalassemia. Saudi Med J. 2006 Jul;27(7):982-5.

19. Duman O, Arayici S, Fettahoglu C, Eryilmaz N, Ozkaynak S, Yesilipek A, et al. Neurocognitive function in patients with beta-thalassemia major. Pediatr Int. 2011 Aug;53(4):519-23.

20. Vichinsky EP, Neumayr LD, Gold JI, Weiner MW, Rule RR, Truran D, et al. Neuropsychological dysfunction and neuroimaging abnormalities in neurologically intact adults with sickle cell anemia. JAMA. 2010 May 12;303(18):1823-31.

21. Zafeiriou DI, Prengler M, Gombakis N, Kouskouras K, Economou M, Kardoulas A, et al. Central nervous system abnormalities in asymptomatic young patients with Sbeta-thalassemia. Ann Neurol. 2004 Jun;55(6):835-9.

22. Shahim S. [Application of the Wechsler Intelligence Scale for Children-Revised (WISC-R) in Iran] persian. psychological research journal. 1993;1(3-4):28-39.

23. Shahim S. [Standardization Wechsler Intelligence Scale for Children in Shiraz] persian. Social Sciences and Humanities University of Shiraz journal. 1993;7(1-2):123-53.

24. Canatan D, Ratip S, Kaptan S, Cosan R. Psychosocial burden of beta-thalassaemia major in Antalya, south Turkey. Soc Sci Med. 2003 Feb;56(4):815-9.

25. Pakbaz Z, Treadwell M, Yamashita R, Quirolo K, Foote D, Quill L, et al. Quality of life in patients with thalassemia intermedia compared to thalassemia major. Ann N Y Acad Sci. 2005;1054:457-61.

**Tables:**

Table 1. Frequency distribution of participants according to gender and city.

|  |  |  |  |
| --- | --- | --- | --- |
| **Healthy**  **Mean ± SD** | **sick**  **Mean ± SD** | **City** | **Gender** |
| 1.31±9.5 | 1.33±9.57 |
| 10 | 10 | **zahedan** | **Girl**  **(n=40)** |
| 10 | 10 | **Shiraz** |
| 10 | 10 | **zahedan** | **Boy**  **(n=40)** |
| 10 | 10 | **Shiraz** |

Table2. Mean verbal, performance, and full IQs and 12 subscales of β-thalassemic major children and their healthy counterparts.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **p-value** | **t** | **Healthy (n=40)**  **Mean ± SD** | **Sick (n=40)**  **Mean ± SD** | **Subscale** |
| 0.001 | -6.92 | 10.65**±** (1) | 8.37**±** (1.82) | **Information** |
| 0.63 | .47 | 10.75**±** (1.12) | 10.9 **±** (1.66) | **Similarities** |
| 0.001 | -8.45 | 9.75**±** (1.17) | 7.07**±** (1.62) | **Arithmetic** |
| 0.53 | -0.62 | 10.77**±** (1.56) | 10.55**±** (1.64) | **Vocabulary** |
| 0.001 | -6.48 | 10.90**±** (1.14) | 8.72**±** (1.54) | **Comprehension** |
| 0.001 | -5.04 | 9.45**±** (1.15) | 7.85**±** (1.64) | **Digit span** |
| 0.001 | -5.21 | 10.9**±** (0.98) | 8.95**±** (2.11) | **Picture completion** |
| 0.001 | 4.54 | 10.50**±** (0.90) | 12.1**±** (2.03) | **Picture arrangement** |
| 0.43 | -0.78 | 10.57**±** (0.84) | 10.37**±** (1.37) | **Block design** |
| 0.02 | 2.22 | 10.70**±** (0.91) | 11.35**±** (1.64) | **Object assembly** |
| 0.008 | -2.71 | 10.05**±** (1.23) | 8.92**±** (2.31) | **Symbol Search** |
| 0.004 | -2.98 | 10.40**±** (1.27) | 9.25**±** (2.07) | **Maze** |
| 0.001 | -5.56 | 104.42**±** (6.38) | 96.27**±** (6.71) | **Verbal intelligence** |
| 0.82 | 0.22 | 105.10**±** (4.80) | 105.40**±** (7.17) | **Performance intelligence** |
| 0.001 | -3.37 | 105.70**±** (5.65) | 101.27**±** (6.08) | **Full intelligence** |

1. Mini Menal Status Interview [↑](#footnote-ref-1)