

Robert Fletcher, Earl Loschen, Chrissoula Stavrakiki and Michael First Kingston (eds), *DM-ID, Diagnostic Manual-Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability*

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“Reason is emotion’s slave and exists to rationalize emotional experience” (Bion 1970, p. 1). One of the most distinguished theoreticians and clinicians in the history of psychoanalysis thus launches his text, *Attention and Interpretation: A Scientific Approach to Insight in Psychoanalysis and Groups*. In that text, Bion attempts to rationally organize the emotional and cognitional data of human experience and its disorders into clinically useful insights. Today, almost 50 years later another laudable attempt at this aim, although in a different métier, can be found in the *Diagnostic Manual-Intellectual Disabilities: A Textbook of Diagnoses of Mental Disorders in Persons with Intellectual Disabilities (DM-ID)*. This most recent effort to make sense out of the behaviors of persons with complex, and oftentimes undecipherable, mental functioning stands as a significant contemporary contribution to this daunting challenge. DM-ID has emerged as a guide to clinical practice, a reference work, and an educational tool.

In order to provide a needed resource for clinicians who serve persons with a broad range of intellectual disabilities, the National Association for the Dually Diagnosed in cooperation with the American Psychiatric Association (APA) has produced a volume, the DM-ID, which may be considered complementary, a companion, to the APA’s *Diagnostic and Statistical Manual of Mental Disorders IV-Text Revision (DSM IV-TR)* (American Psychiatric Association 2000). DM-ID is a 552-page textbook with 28 chapters that cover assessment and diagnostic procedures, a discussion of the construct of “intellectual disability (ID),” and the

range of DSM IV-TR diagnostic categories. Each of the chapters on mental disorders covers DSM IV-TR criteria, and then painstakingly attempts to correlate these with issues and adaptations suitable for those with intellectual disabilities. Literature reviews, expert consensus, and the Cochrane Library method of evaluating treatment were drawn upon. A dearth of available research generated statistics in the area where mental disorders and ID coexist is acknowledged. Tables at the end of these chapters juxtapose DSM IV-TR criteria with one column for those with mild to moderate ID and a second one for those with severe to profound ID. Begun in 1998 under the editorship of Robert Fletcher, Earl Loschen, Chrissoula Stavrakiki, and Michael First, and a host of international experts, including field trials in 2006, this achievement has come to fruition. Moreover, the previously errant clinical tendency of “diagnostic overshadowing,” or under-recognizing mental disorders in persons with ID, is aptly addressed and corrected.

The general term *disability* denotes significant functional problems such as marked and severe problems in the capacity to perform (internal impairment), the ability to perform (limitation), and the opportunity to function in specific contexts (participation restriction). The Developmental Disabilities Act (Public law 106–402, 2000) encompasses all forms of disability. These are characterized as severe, chronic disabilities, attributable to a mental or physical impairment or combination, manifested before age 22 years, likely to continue indefinitely, and resulting in substantial functional limitations in three or more areas of major life activity. DM-ID defines *intellectual disability* as “a condition that affects a person’s ability to learn and function independently. The three features of Intellectual Disability are (1) subaverage general intellectual functioning, (2) significant limitations in adaptive functioning, and (3) onset before the age of 18 years” (p. 63). About 1–3% of

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the entire general population is believed to be in the ID range (p. 66). We are reminded that the older and less preferable term *mental retardation* (MR) is synonymous with ID. The DM-ID regards ID as a “mental disorder” (p. 24) and as a “developmental disturbance” (p. 71). The American Association on Intellectual and Developmental Disabilities (AAIDD) (formerly the American Association on Mental Retardation [AAMR]), having a different emphasis, defines intellectual disability as a particular state of functioning that begins in childhood, is characterized by limitation in both intelligence and adaptive skills, is neither a medical nor a mental disorder, and that life functioning can improve (Luckasson et al. 2001). The DM-ID perspective is similar to that of the APA’s DSM IV-TR. Differing perspectives are important to recognize since each has diagnostic, treatment, social, political, statistical, and financial reimbursement implications, all of which are pragmatic with real world, concrete consequences.

An overarching aim of DM-ID is to emphasize the fact that dual diagnosis is a common finding in the ID population, that is, a diagnosis of intellectual disability along with a diagnosis of a mental disorder is a prevalent phenomenon. It is stated that individuals with ID have been estimated to be two to four times more likely than those in the general population to experience psychiatric disorders (p. 2). Biological, psychological, and social risk factors have been identified. In addition, researchers have found that as many as one third or more of all people with ID have significant behavioral, mental, or personality disorders requiring mental health services (p. 2). Hence, DM-ID has adapted DSM IV-TR diagnostic criteria, where appropriate, in order to facilitate diagnosing individuals with ID who have coexisting mental health needs. The group of persons with mild ID (about IQ 50–70) constitutes almost 85% of the ID population, and may be most appropriate to consider in this regard.

I would like to comment on several aspects of this rich undertaking. In addition to addressing the breadth of inclusion criteria, DM-ID clearly acknowledges DSM IV-TR’s exclusion criteria. For example, Attention-deficit/hyperactivity disorder may not be diagnosed along with Autistic Disorder or any Pervasive Developmental Disorder (PDD); Reactive Attachment Disorder may not be diagnosed with PDD or any ID; Reading Disorder is not diagnosed with Autistic Disorder; and Stereotypic Movement Disorder is not diagnosed with Autistic Disorder. These admonitions are recognized although DM-ID explicitly allows the possibility of coupling the aforementioned as long as one uses DM-ID adaptational criteria. Separate chapters are devoted to Obsessive Compulsive Disorder and Posttraumatic Stress Disorder since these conditions manifest in exceptionally complex ways in the ID population.

A consideration that might be significant in determining dual diagnoses in persons having intellectual disabilities is that of correctly identifying substantially impairing full syndromes from those that can be considered subsyndromal. This certainly has real treatment implications as, for example, medication, adherence, side effects, and metabolic considerations. This distinction is difficult enough in assessing individuals with typical intelligence and adaptive functioning. It becomes a real challenge when evaluating those with ID. Clinical judgment and information from knowledgeable caregivers who usually accompany such persons in evaluative sessions are of inestimable value.

DM-ID is a long-awaited achievement. It is both comprehensive and detailed. An area of omission, however, and I think a significant one, is the absence of any substantive discussion of the DSM IV-TR diagnosis, Borderline Intellectual Functioning (BIF), v62.89 (Ninivaggi 2005). In the past, this transitional area of intellectual capability (IQ about 70–85) and borderline adaptive skills was termed *borderline mental retardation*. Currently referred to as BIF, it may be present in up to 15% of the population if standardized intellectual and adaptive assessment scales appropriate to the patient and having reasonable reliability and validity are used as parameters. Children and adolescents with BIF typically function in marginal ways in academic settings. Often misdiagnosed as having ADHD and disruptive behavior disorders, ineffective or incorrect treatments are used and compound the confusion. The primary learning limitations of individuals with borderline intelligence and adaptive skills are typically not sufficiently recognized. Needed educational interventions go unrecognized. Depressive and behavior disorders secondary to school failure and low self-esteem result. Currently, there are no mandated services available for these persons. It is my hope that later editions of DM-ID may devote more attention to a discussion of the identification and treatment implications required so that the real needs of this sorely underserved group are no longer eclipsed.

Reviewing this important contribution to the mental health literature has been both pleasurable and educational. I was impressed with several references made to the “inner life” of the intellectually limited individual, despite oftentimes limited verbal skills to communicate feelings and distress. Meaningful diagnostic parameters, to be sure, arise from being able to paint a clinically sensitive portrait of the whole person. Such an understanding helps clinicians to understand better the manner in which disabilities and emotional upheavals impact an individual’s life functioning, let alone his or her needs in the larger social context. Efforts to this end are valuable and should not be underestimated. In addition, it is important to remember that diagnoses are meant to classify signs and symptoms that are substantially impairing and often cause distress.

Adding labels that denote disorders, however imperfect such a process may be, to an individual with needs is meant to focus our attention on needed clinical care. This process aims to construct dynamic interventions in order to deliver the best care. The best clinical care fosters a better quality of life, and builds on the available and potential strengths of a person who already has some available assets and capabilities.

DM-ID is a well-written guide to diagnostic understanding and, by extension, to clinical treatment planning. In addition, it provides direction for further research. Recognition of the extended mental health needs in this population may act to enhance increased psychosocial, educational, and vocational interventions, rather than a more exclusive reliance on psychopharmacological adjuncts. All these considerations increase the chances of overall treatment effectiveness. The use of DM-ID requires adequate training as does the proper use of DSM IV-TR. DM-ID's emphasis on *clinical judgment*—reason and empathy, neither overdiagnosis nor underdiagnosis, flexibility, and a keener sensitivity

to the needs of persons with intellectual and adaptive skill limitations—is praiseworthy. Indeed, DM-ID is a well-needed asset both to all members of a treatment team and to the mental health community at large.

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