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Chapter 2

Where goes borderline intellectual functioning

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Abstract

Borderline intellectual functioning (BIF) is an important and frequently unrecognized co-morbid condition relevant to the diagnosis and treatment of any and all psychiatric disorders. In the *Diagnostic and Statistical Manual of mental disorders* (DSM)–IV-TR, BIF is defined as having an Intelligence Quotient (IQ) in the 71-84 range. In DSM-5 IQ boundaries are no longer part of the classification, leaving the concept of BIF without a clear definition. This modification of the classification of BIF is one of the least highlighted changes in the DSM-5. In this paper we describe the history of the classification of BIF and provide information about BIF and on the importance of placing the concept of BIF in the right context and in the right place in future DSMs and other classification systems like the International Classification of Disease (ICD).

Introduction

One of the least highlighted changes in the DSM-5 is the modification of the classification of Borderline Intellectual Functioning (BIF).¹ Contrary to earlier versions of DSM, Intelligence Quotient (IQ) boundaries are no longer part of the classification, leaving the concept of BIF without a clear definition. IQ scores are, over most of the range, well described by a normal distribution. The term BIF describes the group of people that function on the border between normal intellectual functioning and intellectual disability (ID), between 1 and 2 standard deviations below the mean on the normal curve of the distribution of intelligence, roughly an IQ between 70 and 85. According to the normal curve, as much as 13.6% of the population falls into this category. BIF has always been a difficult concept. It had different names, different boundaries, and travelled through earlier DSMs starting as a solid element of mental deficiency in the DSM I and ending, in DSM-5, as a V-code literally in last place. The classification of BIF in DSM-5 has followed a similar path as in the international classification of disease (ICD).^{2,3,4} And although ICD-11 is not due until 2017, ICD-11 and DSM-5 will likely share the same view.

In DSM-5, similar to the new classification of ID, IQ test scores are removed from the diagnostic description of BIF. This is detrimental to the concept of BIF, since it was the only criterion left. Within the classification of ID, even in DSM-5, the importance of standardized IQ scores is well described. As a V-code BIF ultimately has been defined solely by IQ. By removing the IQ criterion, DSM-5 no longer provides any criteria for what exactly is BIF. ICD-11 will probably do the same or might score out the classification of BIF altogether. This, in spite of the fact that it is critically an important and frequently unrecognized co-morbid condition vastly relevant to the diagnosis and treatment of any and all psychiatric disorders.

In this paper we describe the history of the classification of BIF and provide information about BIF and on the importance of placing the concept of BIF in the right context and in the right place in future DSMs and other classification systems like the ICD.

History of borderline Intellectual functioning

Before DSM-I, there were different cut offs in IQ-scores used when it comes to - what is now called - Intellectual disability (ID) or intellectual developmental disorder (IDD). Consequently, ID included what we now call BIF as part of ID. In DSM-I, BIF was called mild mental deficiency, listed in the section *Mental Deficiency*.⁵ The classification applied when there was both an IQ of about 1 to 2 standard deviations below the mean – equalling an IQ between 70 and 85 - and functional impairment. DSM-I already made a plea for a classification based on more than a standardized IQ test alone. It states that cultural, physical and emotional determinants, as well as school, vocational and social effectiveness should be taken into consideration.⁵ In DSM-II, BIF was called borderline mental retardation. It had a place in the section

Mental Retardation.⁶ The boundaries of *borderline mental retardation* (IQ 68-83) differed slightly from those of mild mental deficiency in the DSM-I, but the other criteria remained the same. The place of BIF dramatically changes in DSM-III.⁷ In DSM-III, BIF is no longer part of what by then are called intellectual disorders. *Mental retardation* is now covered in the chapter of disorders usually first evident in infancy, childhood or adolescence. BIF is now a V-code ‘exiled’ to the chapter “V-codes for conditions not attributable to a mental disorder that are the focus of attention or treatment” in the far back of the DSM. The V-code BIF is to be used when the focus of attention or treatment is associated with BIF, i.e. an IQ in the 71-84 range. Where in the classification of mental retardation it is still recognized and described that IQ should not be the only criterion in making a diagnoses of mental retardation or in evaluating its severity, in the V-code BIF, IQ is now the only criterion left.

ICD

In the ICD, borderline intellectual functioning has a similar history being excluded from the section of mental retardation at about the same time.^{2,3} This change obviously caused a significant decrease in the prevalence of ID. In the DSM-III the argument was that the large majority of individuals with borderline intellectual functioning does not have significantly impaired adaptive behavior.⁷ For more than 30 years then, classification of BIF does not change. DSM-III, IV and IV-TR all use the V-code BIF. During the same time in the ICD, BIF got shifted to the residual code R41.8; a rather non-specific code referring to “other and unspecified symptoms and signs involving cognitive functions and awareness”.⁴

Now, DSM-5 has further stripped the definition of BIF. The V-code BIF in DSM-5 is listed in *Other Conditions That May Be a Focus of Clinical Attention*, under *Other Circumstances of Personal History*. It ceases to provide any description of what BIF entails. The DSM-5 just states that the V-code can be used when an individual’s borderline intellectual functioning is the focus of clinical attention or has an impact on the individual’s treatment or prognosis.

Vulnerability and mental health

According to DSM and ICD, BIF is not a disorder. But people with BIF, or an IQ between 70 and 85, do comprise a vulnerable group. Genetic liability, biological causes like perinatal difficulties and epigenetic factors such as socioeconomic status and maternal stress all contribute to BIF.⁸ Children with BIF are uniquely at risk for receiving poor parenting.⁹ Mothers of children with BIF were less positive and sensitive; showed less positive engagement even though their children did not exhibit more difficult child behaviour. Given the importance of positive and sensitive parenting for secure attachment and adaptive regulatory capabilities, children with BIF might be at risk at a very early age.⁹ In adult life, contrary to the DSM-III statement, perhaps increasingly so due to the growing complexity of society, many people with BIF do have pro-

blems in adaptive functioning. In fact, they face difficulties across all areas of ordinary life.¹⁰⁻¹⁴ They are at increased risk of experiencing physical problems,¹³ poverty,¹⁵ have more difficulties with activities of daily living,¹¹ have limited social support^{11, 12} and no access to specialised services.¹⁵ They often live problematic lives, functioning under high strain but unnoticed by the rest of society.¹⁵ Many people with BIF do not have psychiatric disorders, but people with BIF are more vulnerable for the development of mental health problems than people of average or above average intelligence and maybe also more vulnerable than people with mild ID.^{11, 15-20} Several studies show increased risk for the development of almost all psychiatric disorders in childhood as well as in adulthood, including substance misuse and personality disorders.^{11, 12, 16, 17, 21, 22} When people with BIF do develop psychiatric disorders, especially when there are additional problems in adaptive functioning, BIF and its impact on the presentation, diagnostics and treatment of these psychiatric disorders should not be overlooked. Because even though BIF is not a disorder and not a disability by itself, when people with BIF develop a psychiatric disorder, BIF is an impediment in diagnostics and treatment.

Unfortunately, despite the fact that BIF is a vulnerability and has impact on co-morbid disorders, people with BIF are almost invisible in research and – when they develop co-morbid psychiatric disorders – are rarely identified as having BIF in mental health care. The DSM-5 classification of BIF as is, is not likely going to improve on this problem.

Why paying serious attention to BIF remains important

As is the case with many psychiatric diagnoses, the classification BIF can have a stigmatizing effect. People with a low IQ often themselves try to prevent their limited intellectual capabilities being exposed by painstakingly trying to behave ‘normally’ and masking their disabilities and special needs. Also, society as a whole, tries to look away from BIF. For example, people with BIF are not entitled to the special support services for intellectually disabled people because their IQs are deemed too high. Unlike other countries, in the Netherlands, individuals with BIF and co-morbid psychiatric disorders are eligible to the same specialised mental health care services as people with ID. In this way special attention to the impact of BIF on co-morbid psychiatric disorders and the special skills training mental health workers need to treat this patient group is adequately guaranteed. It is doubtful whether general mental health care services are able to deliver the same adequate care. It is important to take BIF into account as a complicating factor from the start of diagnostics and treatment and to train mental health workers in this respect.

At this time however, most mental health care professionals are not trained in recognizing BIF and miss the extra skills needed for effectively treating psychiatric disorders in patients with BIF. Right now psychiatric patients with BIF in regular mental health care are more likely to get psychotropic drugs (and more likely antipsychotics and se-

datives than antidepressants) than psychotherapy.^{11,23} Psychiatric treatments in regular mental health care are not adapted to the cognitive limitations of such patients, like deficits in memory function¹⁷ of patients with BIF. Results from daily clinical practise show that many forms of treatment can be adapted to the cognitive abilities of people with BIF but also that neglect of BIF in psychiatric patients leads to longer duration of treatment, more need for crisis intervention^{11,18} and limited or adverse treatment effect.

Conclusion

We recommend a renewed regard to the concept of BIF and it's place in DSM and other classification systems like ICD. A well-defined classification can improve visibility of patients with BIF in mental health care, bridging the gap between high prevalence and low recognition and acknowledgement. Recognition of patients with BIF and attention to specific mental health care needs is likely to improve the quality mental health care substantially for a group of people that comes last too often. Even in the DSM-5 V-codes.

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