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Research in Developmental Disabilities



Review article

The making of a field: The development of comorbid psychopathology research for persons with intellectual disabilities and autism



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ARTICLE INFO

Article history:

Received 21 September 2013
 Accepted 28 September 2013
 Available online 23 October 2013

Keywords:

Comorbidity
 Developmental disabilities
 Intellectual disabilities
 Autism
 Assessment

ABSTRACT

Knowledge in the area of developmental disabilities has been expanding rapidly. One area that has received particular attention is the topic of related comorbid conditions. This phenomenon is not exclusive to the field of developmental disabilities. However, research with this population is of recent origin. The purpose of this paper is to review the origins of this field including some of the notable developments and potential future trends.

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Developmental disabilities consist of a range of conditions including intellectual disabilities (ID), autism spectrum disorder (ASD), cerebral palsy (CP), sensory impairments, and developmental coordination disorders among others (Boot, Pel, Evenhuis, & van der Steen, 2012; Chen, Wilson, & Wu, 2012; Meyns et al., 2012; Szumski & Karwowski, 2012; van Gent, Goedhart, & Treffers, 2012). These disorders are well defined and have been the subject of assessment and treatment research for decades. This state of affairs is largely due to the severity and chronic nature of these conditions. However, these developmental disabilities may be moderated over time, and various physical and psychological supports can be put into place to assist in establishing more typical functioning.

Early on the development of the psychological and educational treatments was very limited as were assessment methods. Similarly, the understanding of etiology and symptom expression was in its infancy. Persons with ASD were characterized as

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young children (Kanner, 1943). In addition, it was believed that the condition was caused by poor parenting and occurred primarily among well-educated families (Kanner, 1943). An impediment to the comorbid psychopathology field in developmental disabilities was a protracted debate over whether children could experience depression (Costello, 1980; Lefkowitz & Burton, 1978; Timimi, 2004). Many professionals suggested that childhood depression did not exist. Since that time a cultural revolution has occurred with respect to these attitudes. Massive amounts of data are accumulating which contradicts this position. Similarly, ADHD and ASD are now recognized as disorders which co-occur at high rates (Mayes, Calhoun, Mayes, & Molitoris, 2012; Montes & Halterman, 2007). This research has been advanced very recently since the DSM-IV did not allow for a comorbid diagnosis of ADHD with ASD.

The field is maturing at an exponential rate. The basic theoretical foundation of these changes is the recognition of the complexity of human behavior. Developmental disorders overlap with a variety of conditions (Amr et al., 2012; Kishore, Nizamie, Nizamie, & Jahan, 2004; Matson & LoVullo, 2008; Matson, Smiroldo, Hamilton, & Baglio, 1997; Matson et al., 1999). Additionally, researchers are becoming aware not only that co-occurring disorders exist within the context of ID and ASD, but also that these developmental conditions put individuals at an increased risk of comorbid psychopathology (Smith & Matson, 2010a, 2010b, 2010c). It is critical to be able to accurately diagnose these comorbidities in order to plan and implement comprehensive intervention packages (e.g. Matson et al., 2005; Rojahn, Aman, Matson, & Mayville, 2003).

Becoming increasingly pertinent is the concern of what specific symptoms exemplify overlapping disorders, where the cutoff points occur in differential diagnosis, and how to most accurately measure symptoms and diagnose comorbid conditions. As a result, a good method of tracking the field's development is to analyze the number, type, and complexity of assessment methods that have been developed on this topic. For the current review, the focus will be restricted to ID and ASD.

1. Early developments

ID has a longer history of research on comorbid psychopathology compared to ASD. This observation is understandable as ID has a much longer history as a field of study in the disciplines of education, health, and mental health. Binet famously developed the Binet–Simon intelligence test as a method of identifying and separating children with ID into classrooms separate from typically developing children. These developments occurred in Paris and culminated in the first version of the Binet–Simon test in 1905. Later, Terman translated and modified the test for use in the U.S. The first edition of the Stanford–Binet appeared in 1916 with revisions following in 1937 and 1960 (Sears, 1957).

Formative efforts in defining ASD came much later. Almost 40 years had passed since the development of the Binet–Simon before Kanner (1943) first described autism in a professional journal. Even at that point, major modifications and changes to the diagnosis of ASD continued, with scale development following even later. This preoccupation with defining core symptoms in our view was an impediment to the development of the field of comorbid conditions.

For some time after the development of modern definitions of ID and ASD, and accompanying tests to help identify these conditions, comorbid conditions had not been addressed. Additionally, various rationales for why these disorders could not overlap with mental health conditions, in particular, were common. Insufficient ego strength or poor insight into their own problems were reasons cited for these beliefs. It was not until the 1960s that researchers began to acknowledge the presence of co-occurring psychopathology among persons with ID (Gardner, 1967).

Despite these developments, there was considerable resistance to change in the field. One of the primary difficulties was the general separation of services into two tracks: ID and mental health. Thus, persons with ID and mental health concerns often found themselves in a proverbial health services no-man's-land. This service model also shaped how services were provided and how patients were viewed. The ID centers and outpatient programs tended to focus on psychological and educational services. Over time these services became more and more focused on methods and procedures adhering to an operant conditioning paradigm. These methods as a group are often referred to as applied behavior analysis. The mental health side, conversely, adopted a medical/biological model. The focus has been on differential diagnosis and psychotropic medication. Supportive psychological therapies were also employed in some instances. Thus, the types of services received were greatly affected depending on to which of the two types of agencies the individual was assigned. In truth, another problem with this approach was that both treatment models have merit. However, while these methods certainly could complement one another, that approach was seldom followed. Rather, many professionals tended to gravitate to one model or the other. The opposing camp was viewed as a rival treatment model rather than a potential asset to a particular program. The notion was more about sorting out if the person fell into an ID or a mental health box, with no consideration for overlap. This drastically limited the focus on comorbid mental health conditions in persons with ID.

ASD also developed as a singular disorder with respect to the delivery of services. Once the condition had been defined, early researchers were of the opinion that the disorder was rare and occurred among children with above average intelligence. As a result, most programs tended to be housed in medical schools or were administered by private providers. It was not until the 1960s and 1970s that the disorder was reframed. At this point, ASD made the move from being defined as a mental health disorder to a developmental disorder. Later, it became evident that a high overlap occurred between ASD and ID (Hill & Furniss, 2006; Matson & Shoemaker, 2009). In essence, this became the first major advance into the field of ASD and comorbidity. One could also argue that research showing as many as 70% of individuals with ASD also evince ID hastened and solidified the establishment of ASD as a form of developmental disability.

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