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Redefining Intellectual Disability

Intellectual disability (ID) is "a disability characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behavior, which covers a range of everyday social and practical skills" (aaidd.org). There are approximately 3 million people diagnosed with ID in the United States (Larson, Lakin, Anderson, Kwak, Lee, & Anderson, 2001), with an estimated prevalence of 1% of the population (Maulik, Mascarenhas, Mathers, Dua, & Saxena, 2011).

The diagnosis of ID has undergone numerous redefinitions, most recently by: the American Association on Intellectual and Developmental Disabilities (AAIDD) publication of ***Intellectual Disability: Definition, Classification, and Systems of Supports (11th Edition)*** (2010); and the American Psychiatric Association (APA) publication of the ***Diagnostic and Statistical Manual of Psychiatric Disorders – Fifth Edition*** (DSM 5) (2013).

Current diagnostic criteria for ID continue to include the requirement for deficits in both adaptive behavior and intellectual functioning (APA, 2013). However, several important definitional and diagnostic changes have occurred in the past 20 years including:

A change of term from "Mental Retardation" to "Intellectual Disability,"

A shift in concept of ID from a "static, lifelong disability" to a condition "enhanced by provision of support" (AAIDD).

Of particular importance is a change in the diagnostic approach to *severity* of ID (i.e., mild, moderate, severe, or profound). Previously (in DSM-IV-TR, APA, 2000), the severity of ID was based upon IQ score. Individuals with lower IQ scores were considered to have a greater severity of ID (e.g., *mild* ID was defined as an IQ score between 55 and 70, *moderate* ID was defined by an IQ score between 40 and 55, etc.). Currently (in DSM 5), deficits in adaptive functioning have become central in the determination of ID severity. Instead of IQ score, the severity of ID is now determined based on the extent of the individual's reported dysfunction in the adaptive domains of conceptual, social, or practical functioning. This parallels the approach taken with Autism Spectrum disorders in the DSM 5.

With this change, the severity of ID is more relevant to intervention planning, since the extent of adaptive dysfunction (more than IQ score) tells more about the level of support an individual needs. Therefore, severity of ID is an important consideration when assessing for both eligibility and extent of need for special education services; home and community-based services; Social Security Administration and/or Developmental Disability Administration benefits, and the like.

General Assessment Considerations

According to DSM 5, there are several necessary components to evaluate when considering the diagnosis of ID:

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Demonstrating that the condition began during "the developmental period."

o It is important to establish that the condition began during childhood or adolescence, as this distinguishes it from skill loss or deterioration attributable to conditions recognized to have adult onset, such as most dementia syndromes.

o ID can be diagnosed when an individual is a young adult, but a clinician should review the developmental history, school records in addition to previous assessments if possible, for evidence that the condition has been life-long in nature.

An IQ test, with demonstration of intellectual deficits.

o Establishment of an intellectual *deficit* (vs. intellectual *disability*) is defined by a score of two or more standard deviations below the mean on an IQ test. DSM 5 provides a guideline of an IQ score of less than or equal to 70 (plus or minus 5 standard score points for error; APA, 2013) as acceptable for documenting intellectual deficits.

o Clinical judgment should be used when assessing IQ, and test scores should be interpreted within an individual's context as should potential threats to the validity of test scores, including whether:

- The test is "out of date" (i.e., normative data that is over ten years old)
- Co-occurring conditions (e.g., language disorder) or interfering behaviors; (e.g., inattention, impulsivity) exist that can negatively impact test performance;
- The test is normed "for the individual's sociocultural background and native language." (APA, 2013). Most current IQ tests have versions in a variety of languages. It is strongly recommended that IQ assessment be conducted in an individual's primary language with a test administrator fluent in that language if at all possible.

Assessment of adaptive behavior, with demonstration of adaptive dysfunction.

o In the past, DSM-IV-TR required demonstration of adaptive skill deficits in two or more (out of 10) *areas* of adaptive functioning to meet diagnostic criteria. This was changed in DSM 5 to adaptive deficits in at least one of three broad *domains* (i.e., conceptual, social, or practical).

- In most models, the *areas* of adaptive functioning are thought to be included in the broader *domains* of adaptive functioning. For instance, the skill areas of *Community Use, Home Living, Health and Safety,* and *Self-Care* all fall within the overarching *Practical* domain (Adaptive Behavior Assessment System (ABAS-3); Harrison & Oakland, 2015).

o Adaptive deficits in conceptual, social, or practical domains can be captured through clinical interview or the use of adaptive skill inventories. Information regarding a youth's adaptive functioning is typically learned from a parent/guardian, teacher, counselor, etc., as well as by the youth if possible.

o While adaptive functioning has historically been defined as a set of "skills" (e.g., activities of daily living, hygiene skills, domestic abilities), seen in likely environments, clinicians should consider the potential for discrepancy in "real-world" problem solving, gullibility, and vulnerability to exploitation (Greenspan, 2006), particularly in new, different or less routine situations.

o Information learned from an adaptive skill inventory may be useful for establishing a shortfall in a domain of adaptive functioning. However, there are no specific DSM 5 guidelines regarding ranges of scores for identifying different levels of ID severity. As such, reporting adaptive skill inventory scores *alone* is not considered sufficient for the documentation process.

o The presence and severity of adaptive dysfunction is determined in great part by a clinician's impressions of the youth's functioning and level of needed support. In most cases, adaptive deficits are determined by "both clinic evaluation and individualized, culturally appropriate, psychometrically sound measures" (American Psychiatric Association, 2013). To facilitate the clinical evaluation, the DSM-5 provides a table linking narrative descriptions of adaptive dysfunction in conceptual, social, and practical domains with degrees of severity of impairment (American Psychiatric Association, 2013).

Specialized Assessment Considerations

- The diagnosis of ID presumes a causal relationship between the intellectual and adaptive deficits, in that "the deficits in adaptive functioning must be directly related to the intellectual impairments described" (American Psychiatric Association, 2013). This is an important clinical consideration of diagnosis, as adaptive dysfunction is commonly reported in individuals with a variety of developmental disorders, many of whom do not have intellectual deficits.

- As such, a clinical evaluation must determine the extent to which adaptive dysfunction occurs due to intellectual deficits, and distinguish this from adaptive dysfunction attributable to physical limitations or cognitive variables other than intelligence (e.g., executive functioning; Culhane-Shelburne, Chapieski, Hiscock, & Glaze, 2002; Papazoglou, Jacobson, & Zabel, 2013).

- Additionally, the clinical evaluation must consider if concerns regarding the youth's intellectual or adaptive functioning can be explained by their community environment, linguistic diversity, or cultural differences (AAIDD, *Intellectual Disability: Definition, Classification, and Systems of Supports*).

Summary:

The redefinition of Intellectual Disability in the DSM-5 includes a change in diagnostic term (from Mental Retardation), but also shifts attention from the individual's IQ score to reports of the individual's adaptive and "real world" functioning. This change in emphasis is important for assessment professionals, and is a key component to calibrating the intensity of intervention and support services in order to enhance the capabilities and quality of life of individuals with this condition.

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