Intellectual Disability

Definition, Classification, and Systems of Supports

The AAIDD Ad Hoc Committee on Terminology and Classification

11th Edition

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American Association on Intellectual and Developmental Disabilities

Published by
American Association on Intellectual and Developmental Disabilities
501 3rd Street, NW, Suite 200
Washington, DC 20001-2760

Printed in the United States of America

Library of Congress Cataloging-in-Publication Data

Intellectual disability : definition, classification, and systems of supports / The AAIDD Ad Hoc Committee on Terminology and Classification.—11th ed.
p. cm.
Includes bibliographical references and index.
ISBN 978-1-935304-04-3 (alk. paper)
1. Mental retardation—Classification. I. American Association on Intellectual and Developmental Disabilities.
RC570.C515 2010
616.85'88—dc22 2009040030

are more likely to mask their deficits and attempt to look more able and typical than they actually are (Edgerton, 1967); (b) "mental retardation" has been a particularly stigmatizing and pejorative label that leads most individuals with this label to fight hard not to be identified as "MR"; (c) ID is a social status that is closely tied to how a person is perceived by peers, family members, and others in the community; and (d) persons with ID typically have a strong acquiescence bias (Finlay & Lyons, 2002) or a bias to please that might lead to erroneous patterns of responding. Based on these considerations, the authors of this *Manual* caution against relying heavily only on the information obtained from the individual himself or herself when assessing adaptive behavior for the purpose of establishing a diagnosis of ID.

Individual's Physical Condition and Mental Health

Individuals who exhibit specific sensory, motor, or communicative limitations present special difficulties for accurate assessment. As a consequence, the evaluation of adaptive skills for an individual who may have vision, hearing, or motor impairments frequently becomes a complex process (Meacham, Kline, Stovall, & Sands, 1987). For example, the assessment of individuals with hearing impairments generally requires a nonverbal instrument, whereas the assessment of persons with visual impairments requires measures that do not include object manipulation or cards or pictures. An individual with severe motor limitations may have quite limited voluntary responses and, therefore, may need to respond via an eye scan or blink. Some individuals may exhibit multiple disabilities, thus compounding the task for the assessment specialist. In addition, some may simply lack test-taking skills. As a consequence, they may refuse to stay seated for the duration of an assessment session or may exhibit a high rate of stereotyped or self-stimulatory behavior. Individuals who rely on nonverbal communication may have difficulty making the requisite responses indicated for a given test. Additional problems may include fatigue, low levels of frustration, motivation, noncompliance, limited comprehension of instructions, drowsiness due to medication, and test anxiety (Evans, 1991; Pollingue, 1987). Finally, and significantly, a general principle is that the test results should not be unduly affected by limitations in receptive or expressive language capabilities. Such limitations may cause the test to be a measure of the problem rather than a valid assessment of adaptive skills.

Identifying Factors That Influence Adaptive Behavior Scores

For purposes of diagnosis, it is also important to identify factors that typically affect the learning or performing of adaptive skills. Some of the more important factors are discussed below.

Opportunities. Opportunities to participate in community life must be considered in decisions about significant limitations in adaptive behavior. A person whose opportunities to learn adaptive skills has been restricted in comparison to same-age peers may have acquisition deficits unrelated to ID. For example, a person with ID who has a lower IQ

and who has not been provided opportunities to make purchases is likely to lack the adaptive skills needed for shopping.

Relevant context/environments. Adaptive behavior needs to be evaluated in relation to contexts typical of the individual's age peers. However, in some cases, typical behavior is observed in "atypical" environments. This disconnect must be taken into account in the clinical interpretation of scores. A second issue is that in some contexts raters will have no direct information about the individual's typical performance of a specific behavior or a behavior that occurs in another setting. For example, the Adaptive Behavior Assessment System-II (Harrison & Oakland, 2003) allows the respondent the option to "guess" a rating for a specific behavior that might not have been observed directly by the respondent. Thus, the respondent is providing an estimate of the assessed individual's typical behavior based on their knowledge of the person. The reliability of ratings that are not based on personal observation of typical behavior must be evaluated cautiously. In fact, Harrison and Oakland (2003) recommend a cautious interpretation of any domain in which the respondent "guessed" on more than three items.

Sociocultural considerations. Clinicians considering a diagnosis of ID must take into account the cultural context of the individual. The key challenges are to describe important sociocultural differences and, subsequently, "to evaluate the individual's status in light of expectations and opportunities for the development of various competencies" (Reschly, 1987, p. 53). Behavioral expectations may differ across cultural groups, along with education and training in adaptive skills. Assessments, therefore, must consider relevant ethnic or cultural factors and expectations (Tassé & Craig, 1999). This issue, which some believe is not relevant for basic behaviors contained on adaptive behavior scales (e.g., persons in all ethnic or socioeconomic groups are expected to perform daily living skills with increasing independence as they get older), has received increasing attention. Because it would be impossible to obtain many standardization samples to represent all cultural variations in the United States, this may need to be dealt with in the clinical interpretation of scores rather than the actual scoring procedure. The authors of this *Manual* also strongly discourage any score corrections that are not part of test procedures that attempt to correct for any cultural or socioeconomic factors that are thought to impact the individual's scores on a standardized adaptive behavior scale. Until firmly supported by empirical evidence, we strongly caution against practices such as those recommended by Denkowski and Denkowski (2008).

GUIDELINES FOR SELECTING AN ADAPTIVE BEHAVIOR SCALE FOR THE PURPOSE OF DIAGNOSING ID

Table 5.2 summarizes current practice guidelines for selecting the best adaptive behavior measure for a particular individual or group. These guidelines should be used in conjunction with those discussed in the two previous sections on "Assessment