# Mental Retardation

## Definition, Classification, and Systems of Supports

10th Edition

AAMR
American Association on Mental Retardation

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# PREFACE

Since its founding in 1876, the American Association on Mental Retardation (AAMR) has led the field of mental retardation in understanding, defining, and classifying the condition of mental retardation. The Association has attempted to fulfill its responsibility by formulating and disseminating manuals and related information on terminology and classification through the years.

The AAMR's first edition on definition was published in 1921 in conjunction with the National Committee for Mental Hygiene. A second edition of that manual was published in 1933, and a third in 1941. The Committee on Nomenclature of the AAMR (then the American Association on Mental Deficiency) published the fourth edition in 1957, which was an etiological classification system.

The fifth edition, a comprehensive manual on terminology and classification, was published in 1959 (Heber) and reprinted with minor corrections in 1961 (Heber). Two dramatic changes in the 1959 manual were raising the IQ ceiling to one standard deviation below the mean (i.e., an IQ of approximately 85 or below) and the formal introduction of an adaptive behavior criterion to the definition of mental retardation.

The sixth edition (Grossman, 1973) lowered the IQ ceiling to two standard deviations below the mean (i.e., an IQ of about 70 or below). Several other important changes were introduced in the 1973 manual, including: (a) inserting the word *significantly* before the term *subaverage general intellectual functioning*; (b) raising the limit of the developmental period from age 16 to 18; and (c) omitting the borderline level of retardation (i.e., IQ about 70 to 85).

The seventh edition (Grossman, 1977) included relatively minor corrections and changes.

The eighth edition (Grossman, 1983) further clarified that the upper IQ range for the diagnosis of mental retardation was a guideline and with clinical judgment could extend to approximately 75.

The ninth edition (Luckasson et al., 1992) of the manual retained some aspects of the 1983 definition and classification system (e.g., the IQ guidelines of approximately 70 to 75 or below), but departed from the previous definitions and classifications systems in four important ways: (a) it expressed the changing understanding that mental retardation is a state of functioning; (b) it reformulated what ought to be classified (intensities of supports) as well as how to describe the systems of supports that people with mental retardation require; (c) it represented a paradigm shift, from a view of mental retardation as an absolute trait expressed solely by an individual to an expression of the interaction between the person with limited intellectual functioning and the environment; and (d) it extended the concept of

adaptive behavior another step, from a global description to specification of particular adaptive skills.

The 2002 10th edition, *Mental Retardation: Definition, Classification, and Systems of Supports,* reflects 10 years of experience with — and critiques of — the 1992 System. During that time, the AAMR Terminology and Classification Committee has held public forums, integrated the literature on mental retardation since 1992, and sought input from Association members and others. This work has greatly benefited from the generous comments and challenges of many. The result is found in the ensuing 12 chapters that build on the 1992 System. Key aspects of the 2002 System include:

- The 2002 System retains: (a) the term *mental retardation*; (b) the essential features of the 1992 System including its functional orientation and supports emphasis; (c) the three diagnostic criteria related to intellectual functioning, adaptive behavior, and age of onset; and (d) maintains a strong commitment that classification based on intensities of needed supports should be the primary focus of a classification system and the preferred direction for the field.
- The 2002 System incorporates: (a) a standard deviation criterion to the intellectual and adaptive behavior components; (b) a fifth dimension of Participation, Interactions, and Social Roles; (c) factor analytic and conceptual work on adaptive behavior that suggests that conceptual, social, and practical skills can adequately represent this multidimensional component of the definition; (d) recent work on supports assessment and supports intensity determination; (e) an expansion of the previous three-step process into a Framework for Assessment; (f) an expanded discussion regarding diagnostic and classification considerations and recommendations regarding other populations including "the forgotten generation"; (g) an expanded discussion of clinical judgment in reference to the circumstances in which it is required, its definition, and a number of clinical judgment guidelines; and (h) a discussion of the relationship between the 2002 System and other classification systems, such as *DSM–IV, ICD–10,* and *ICF.*

The manual retains the term *mental retardation.* Many individuals with this disability urge elimination of the term because it is stigmatizing and is frequently mistakenly used as a global summary about complex human beings. After considerable deliberation by a number of groups, there is no consensus of an acceptable alternative term that means the same thing. Thus, at this time, we were unable to eliminate the term, despite its acknowledged shortcomings. The purpose of the 2002 manual was to define and create a contemporary system of diagnosis, classification, and systems of supports for the disability currently known as mental retardation. To accomplish that, we had to use the commonly understood term for the disability.

With the 1992 System, the concept of mental retardation was expanded signif-

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icantly with the emphasis on a functional orientation, an ecological perspective, and the use of the supports paradigm for both classification and service provision purposes. Based on the critiques of the 1992 System, the AAMR Terminology and Classification Committee, which authored the 2002 manual, recognized that although we were attempting to respond to the paradigm shift in mental retardation, we needed to attend to ensuring adequate and appropriate services to users of the system. Our primary challenge in 1992 was to reflect the paradigm shift; the challenge of the 2002 System has been to integrate the vast amount of commentary and research that has occurred since the 1992 System's publication and to operationalize more clearly the multidimensional construct of mental retardation and best-practice guidelines regarding diagnosis, classification, and planning supports for individuals with mental retardation.

The field of mental retardation is currently in a state of flux regarding not just a fuller understanding of the condition of mental retardation, but also the language and process used in naming, defining, and classifying. For example, we are in the midst of discussions about the nature of intelligence; the relationship between intelligence and adaptive behavior; the implementation of the supports paradigm; the best way to conceptualize disabling conditions; the impact of consumer and reform movements; and the effects of terminology upon individual lives.

This state of flux is both frustrating and challenging. It is frustrating because it prohibits one from relying on past language, definitions, and models of mental retardation that can be a source of stability and permanence to some. However, the state is also challenging, as it provides the opportunity to incorporate the current and evolving understanding of the condition of mental retardation and the factors that influence the lives of people in their societies. Whether perceived from a positivistic or social perspective, the condition of mental retardation is being thought of differently today throughout the world. The 2002 AAMR *Definition, Classification, and Systems of Supports* captures that changed vision and builds on our more than 125 years of collegial work, attempting to understand and support individuals with mental retardation.

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