

# Is there a medical definition to consider when diagnosing intellectual disability?

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It was initially considered appropriate to think of intellectual disability as a single category — part of the classifications of mental disorders identified by people such as Pinel, Esquirol, and Kraepelin. However, when diagnosing intellectual disability in Japan, it becomes clear that the original Japanese Law for the Welfare of with Intellectual Disabilities does not have any clear definitions, it simply includes a notice from the deputy-minister that safeguards must be in place for serious cases. As a result, we followed the content of diagnostic manuals published approximately every 10 years by the American Association on Mental Retardation (AAMR), established in 1876. Before World War II, there was neither a specific system of treatment in place, nor any concept of support methods. This is shown by Tredgold's statement that a "person affected [by intellectual disability] is unable to perform his duties as a member of society". One major step forward came in

1961, with Heber's famous definition that attempted to tackle the intellectual-disability category from the perspectives of both intellectual function and adaptive behaviour. This definition used a cut-off value of 1 standard deviation on the WAIS scale — in other words, an IQ of 85. This would include 16% of the entire population, and in practice was used less for providing welfare services to people and more for cutting off immigration and segregating education by race. Considering the times, this definition can be considered an aspect of the impact that the launch of Sputnik in 1957 by the Soviet Union had on the educational world.

Following this, Grossman's 1973 definition encompassed intellectual disability, adaptive behaviour, and a developmental period up to 18 years of age. It also defined a more appropriate cut-off value of 2 standard deviations (IQ 70 or lower, 3% of the population). However, as the civil rights movement

progressed and people called for more rights and support for the disabled, in 1992, Luckasson et al took the 70–75 definition and added 10 adaptive behaviour regions, two of which are diagnosed as intellectual disabilities that clearly require support. Categorization of severity according to numerical values was eliminated and the definition called for support systems to be created for each impaired person, divided by support type and intensity. This definition was developed at the same time as the DSM-IV was issued. While DSM retained severity categories, it largely followed in the same line as Luckasson's definition. However, due to the large number of adaptive behaviour regions and elimination of severity categories, many US states found that the definition made it more difficult to get a clear picture of intellectual disability. As a result, it saw little actual use.

Luckasson's revised version from 2002 is thought to be the most broadly accepted worldwide. The 2sd and the standard of an IQ of 70 or lower for intellectual deficiency and adaptive behaviour were revised to assess ability in three different regions: notional, societal, and practical. This was used in DSM-5, the reasons for which are discussed in detail within the concrete adaptive-behaviour examples written by AAMR (now known as AAIDD) and also

included in miniDSM. It is best to suitably diagnose the various problems in social adaptation shown by people with intellectual disabilities in order to help envision a direction for support. However, we have suspicions that the move to increase the number of intellectual-disability diagnoses in the US is partly due to a drive to reduce medical costs.

Regardless, while technical problems remain (including which test battery to use and the mental state of the test-taker at the time of examination), after considering the historical process outlined above, we share the outlook of administrative officers from the city of Yokohama that defining intellectual disability is something decided based on administrative and political factors, and that there is no medical standard.

It is impossible quantify adaptive behaviours, forcing us to imagine asking for the release of evaluation details. However, based on the text of ICD-10 and interpretations from Zigler et al in the US, making a determination of intellectual disability based on IQ alone does not seem to go against the times in a serious manner. However, in order to offer more leeway and leave some room for error, the cities of Kawasaki and Tokyo, as well as Kanagawa prefecture, have adopted a standard of an IQ of 75.

Moreover, since starting my evaluation business, we have come to realize that autism—a major complication of intellectual disability—requires special consideration. Autism was added to US developmental-disability law in the year 1975 and an additional resolution for autism was passed by the Japan House of Councilors upon revising the Basic Act for Persons with Disabilities in 1994. Kanagawa prefecture's evaluation groups have decided to consider operating under these standards. Based on previous experience, autism often comes with other intellectual complications. As a result, instead of delivering a new disability certification specifically for autism, we have determined that adding it as an intellectual disability is the most valid direction to take. As for evaluating the IQ of autistic patients, both Kanner and Asperger there have been scepticism about the meaning of IQ values calculated for their cases, and we have shared same view. However, given the knowledge that governments are forced to work with clear cut-off values, we have used our evaluation experience and standard-deviation error ranges to come up with a ballpark value of an IQ of 91. This was enacted beginning 2001, after the additional resolution was passed.