The American Association on Mental Retardation (AAMR) publishes an edited manual approximately every 10 years on terminology, classification, and clinical judgment related to mental retardation and disability. Similar to the 9th edition (Luckasson, 1992), in this 10th edition, mental retardation is defined as:

A disability characterized by significant limitations both in intellectual functioning and in adaptive skills. This disability originates before age 18. Further, five assumptions are essential to the application of this definition:

1. Limitations in present functioning must be considered within the context of community environments typical of the individual's age peers and culture.

2. Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor, and behavioral strengths.

3. Within an individual, limitations often coexist with strengths.

4. An important purpose of describing limitations is to develop a profile of needed supports.

5. With appropriate personalized supports over a sustained period, the life functioning of the person with mental retardation generally will improve.

Mental retardation is described not as an absolute trait, but instead, as an ever-changing interaction between the individual's intellectual and adaptive abilities, participation in activities, interactions with others, social roles, and health. These factors are then considered in the context of the individual's immediate and cultural environment in determining supports. The term mental retardation is retained in this edition because, according to the authors, no consensus could be reached on another term.

The first section of the manual, overview and development, including these definitions of mental retardation, and related terminology, also provides an historical perspective on the definition of mental retardation over a 100-year period. A most notable change in the definition was presented in the 9th edition when the method of classifying levels of severity was redefined. Previously, these levels were determined by IQ score and were classified in categories of mild, moderate, severe, and profound. In the new classification schema, levels are determined by degrees of needed supports. Thus, in the new definition classifications are based on information from a variety of sources instead of results of a single IQ test.
The authors in this edition devote a large portion of Chapter 2 to positive and negative reactions to the definition of mental retardation. Those who voiced positive reactions praised the focus on support needs instead of impairments. Negative appraisals included the subjective nature of intensity of supports. Some feared that those who had been classified with mild mental retardation would no longer be eligible for services. The authors of this edition respond to critics of the 1992 definition with a model of needs proposed by Greenspan (in press). Greenspan is quoted as saying, "If mental retardation is real, then it must be grounded in the demonstrated incompetencies, needs, and vulnerabilities that cause individuals to be seen as needing supports and protections." He proposes that incompetencies fluctuate across an individual's lifetime. Individuals may be diagnosed with mild mental retardation while enrolled in school, but may have no incompetencies when they leave school. In what appears to be contrary to Greenspan's model, AAMR still proposes that the criterion for diagnosis of mental retardation include test scores that are two standard deviations below the norm on an IQ test and two of three areas of an adaptive behavior assessment.

The second section, diagnosis, covers the assessment of intelligence, adaptive behavior, and diagnosis and clinical judgment. Discussion of adaptive behavior in Chapter 5, for example, includes three areas of adaptive behavior: conceptual skills, social skills, and practical skills. The interaction of adaptive behavior and diagnosis, specific tests for assessing adaptive behavior, and the role of problem behaviors also are discussed.

In the third section, classification, major classification systems are described and compared with the AAMR classification system. The International Classification of Functioning, Disability, and Health (ICF) developed by the World Health Organization is described as the most compatible with the AAMR system and is particularly useful in etiological classification. The Diagnosis and Statistics Manual: Mental Disorders (DSM), the Developmental Disabilities definition, social security definition, Medicaid Intermediate Care Facility (ICF-MR), and Medicaid Waiver definitions are also described and compared.

The fourth section, supports, includes chapters on supports for individuals with mental retardation, physical and mental health, and public responsibility in the provision of supports. A committee of AAMR recently completed an assessment tool for identifying needs and designing supports plans (Thompson, Hughes, Schalock, & Silverman, in press). Chapter 9 outlines a generic version of that assessment, beginning with an identification of discrepancies between the individual's abilities and capabilities, and the adaptive skills and competencies required to function in the individual's environment. Discrepancies are evaluated in nine areas: human development, teaching and education, home living, community living, employment, health and safety, behavioral, social, and protection and advocacy. Supports are then determined in order to reduce identified discrepancies. Supports may include teaching, befriending, financial planning, employee assistance, behavioral support, in-home living assistance, community access and use, and health assistance. Further, supports may be provided by family and friends or by professionals.

The final section, implications, provides a summary of the other chapters. Sections of the chapter are devoted to how the AAMR model will impact current education and habilitation services, research design, eligibility for services, and legal accommodations.

This book will be a useful resource for both professionals and lay persons who are interested in, work with, or are advocates for individuals with either a diagnosis of mental retardation or individuals who score within normal levels on
IQ tests, but have significant limitations in adaptive skills. The book can be used as a basic source for terminology, diagnosis of mental retardation and related disorders, and classification systems associated with particular reimbursement and funding streams. It also offers a best-practice approach to intervention and support of those with mental retardation. The entire book can be read in 4-6 hours. Some of the information overlaps across chapters, which allows the reader to skip sections of the text. There are also many tables and figures that summarize information for the reader.

Although this book offers something for everyone, most readers will likely disagree with some of the information conveyed. Families, parents, and advocates are likely to dislike the continued use of the term "mental retardation." Others may find the definition too limiting. The authors alluded to "the forgotten generation"; that is, the increasing number of individuals identified who function in the normal range of intelligence but with significant limitations in adaptive behaviors. Others may continue to struggle with the subjective definition for levels of severity. When definitions of levels of severity are based on IQ scores, then classification is very clear. Intensities of support are subjective. Those professionals who assign diagnoses, determine eligibility, or are researchers who use levels of severity to describe the characteristics of research participants typically have little or no experience in designing supports. Another concern of clinicians, teachers, and case managers may be that the AAMR supports model is very complex. Assessing nine areas of competence and developing a system of supports that may be natural or service-delivered, and may be one of eight types of support, require time and expertise. Families, parents, and advocates also must struggle to understand the complexities of terminology and the interaction of etiology, health, and cognitive factors in determining prognosis for improving the individual's functioning. A fear that some service providers have voiced is that, given the complexity of the AAMR supports approach, more supports will be in the form of attendant or respite care, not the supports that will truly allow the individual to function more independently and productively.

The AAMR definition of mental retardation is particularly important today because of recent court decisions concerning the legality of the death penalty for persons diagnosed with mental retardation. Fewer individuals meet the definition of mental retardation using the current definition. Prosecutors of violent offenders will likely refute diagnoses of mental retardation if individuals lived independently prior to their conviction. On balance, defense lawyers are likely to point to the requirement that diagnosis includes the results of standardized tests and that such tests offer insight into reasoning and judgment. Whether the AAMR definition will serve both society and the accused remains to be tested.

(Muriel D. Saunders, Johnson County Developmental Supports, Laneka, KS)