Getting Schooled

Welcome to Getting Schooled and our next article in our series on intervention. Since the publication of the DSM-5, school psychologists have worked diligently to determine the implications for their practice in schools. Changes in certain diagnostic criteria have an impact on how we intervene with students, teachers, and families. Dr. Michael Zwiers provides us with some insights regarding the implications for practice when using this newest version of the DSM, focusing on two commonly diagnosed disorders, Intellectual Disabilities and Specific Learning Disorders. Enjoy!

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DSM-5 and the Provision of Psychological Services in Schools: Intellectual and Learning Disabilities

In May of 2013, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was published. Similar to previous iterations of the manual, there was substantial controversy regarding its contents, including changes to a number of disorders relevant to those working as school psychologists. This article will focus primarily on Intellectual Disability and Learning Disorder, with consideration for a Canadian and Albertan context.

Strengths and Weaknesses of the DSM

"An accurate diagnosis can save a life; an inaccurate diagnosis can wreck one."
- Allen Frances, Chair of the DSM-IV, 2013, p. 242

The DSM system has not been universally embraced (e.g. the International Classification of Disease is the predominant model worldwide in part because the Mental Health section is simpler to use, but perhaps most significantly because it is available for free, which has implications in developing countries). Despite differences in opinion about the quality of the newest edition, the DSM system does have utility. It can help clinicians to clarify unique diagnoses, which can in turn inform treatment and support access to services, programs, and benefits; it can help us to understand and communicate common problems, which serves to normalize experience and reduce stigma; and it can improve education and training and facilitate research endeavours.

Just like any other classification system, the DSM comes with risks. A clinical diagnosis may be incorrect in two ways: the clinician may make a *commission error* and diagnose a disorder that the individual does not have, or the clinician may make an *omission error* and miss making the diagnosis of a disorder that the individual does have. Either of these can result in potential harm to the client. Even when a diagnosis is accurate, harm can occur through negative outcomes like the stigma associated with a diagnostic label; the embracing of a self-fulfilling prophecy by the individual or caregivers who may limit

their prospects; or, the application of more intrusive intervention such as medications that could have detrimental side effects. A diagnosis may actually restrict an individual's access to programs and services (as is common in congregated classroom programs that often deny access to individuals who have significant disruptive behaviour or emotional problems). Finally, there may be unforeseen future consequences such as the individual being denied access to insurance, having limited job prospects, or even being restricted from adopting children.

As psychologists, we are required to communicate potential risks and benefits to clients engaging with our services. The following section will consider challenges associated with the diagnosis of learning and intellectual disabilities using the DSM and offer suggestions based on the Canadian context.

Changes in DSM-5: Neurodevelopmental Disorders

The DSM-5 reformulated the chapter on childhood onset disorders by introducing a neurodevelopmental framework, stating that these disorders typically occur during the development period and impact expected developmental trajectories and outcomes. Within this chapter, a new disorder was quietly inserted: **Global Developmental Delay** (GDD). This new diagnosis is restricted for use with individuals under the age of five when the clinical severity level cannot be reliably assessed. It is used when the individual fails to meet expected developmental milestones in several areas of intellectual functioning and is unable to participate in systematic assessment of cognitive functioning. This new diagnosis does not replace a *provisional diagnosis* of an Intellectual Disability. Importantly, a child given a GDD diagnosis requires reassessment. Unfortunately, the term *Global Developmental Delay* is used differently across the Canadian landscape. In Ontario, for example, the term has been used to identify preschool children who have notable delays in many areas of developmental functioning (including motor, cognitive, social, and others) and it is considered a significant diagnosis. In contrast, the term has been used in Alberta as a way of describing preschoolers with mild delays in reaching developmental milestones, and who are typically expected to improve over time (although early intervention is usually provided).

Intellectual Disability (Intellectual Developmental Disorder)

The revised diagnosis of Intellectual Disability is one of the most unique in the DSM in that it does not contain the word “disorder”. This was primarily the result of successful lobbying by parents and professionals who support individuals with cognitive impairments, and who had worked hard to have this form of impairment recognized as a disability by governments, in turn gaining access to supportive funding and services. The DSM-5 diagnosis requires formal assessment of both cognitive capacity and adaptive functioning (conceptual, social, practical) as in the past; however, the severity level classification (e.g., Mild, Moderate, Severe, Profound) is now determined by the level of adaptive functioning and not a global cognitive functioning score (i.e., I.Q. score). The diagnosis may also be made if the individual achieves a *maximum* standard score of 70(±5) on a recognized measure of intellectual/cognitive ability. Although the new model has merit in that the individual’s level of functional impairment is most

relevant to day-to-day functioning, adaptive functioning is often measured by school psychologists using rating scales that have been completed by untrained observers. This can too-often lead to quite disparate results from different reporters in different settings (e.g., teacher at school versus parents at home). Although an individual's functional capacity may vary across tasks, settings, and domains as well as across time, school psychologists must consider the influence of the rater on test results. Psychologists must also consider their own limitations, as they are typically involved with the individual being assessed for only brief periods of time. DSM-5 offers some support to clinicians by providing a summary table of severity levels, with behavioural descriptions of functioning across domains, which can serve as a reference point. However, these descriptions also refer to supports that are typically needed by individuals in each category, which could easily be inferred to mean that such supports should be provided. This could have significant implications for school districts, which may have different models of service provision or developing and implementing program plans for students.

Suggestions for Practice

Given the challenges of conducting reliable assessments of adaptive functioning, which in turn inform the severity level of the diagnosis, psychologists may consider providing a severity indicator for each domain of functioning (allowing for differences across domains), and even across settings. The severity level of the global diagnosis could also be reported as a range (e.g. *Mild to Moderate*). It is also suggested that assessment take place over a more extended period of time and closely involve adults who have regular contact with the individual being assessed. Finally, adaptive functioning assessment could be conducted with an instrument that may be administered using a semi-structured interview, and which uses a benchmark model for scoring, such as the Vineland Adaptive Behavior Scales. One of the benefits of the DSM-5 approach to intellectual disability assessment is that it emphasizes careful evaluation of various domains of functioning. This can help to remind professionals to use these domains (and subdomains) when developing Individual Program Plans (IPPs) and monitoring student progress, *making the IPP a living document that emerges naturally from the assessment.*

Specific Learning Disorder

The framework for Specific Learning Disorder in the DSM-5 differs in many ways from earlier draft proposals, which implies that the final version was not roundly accepted. The foundational criteria will be familiar: the individual has difficulty learning and using academic skills, in combination with academic performance that is substantially below expectations (based on age, intelligence, or age-appropriate education). It contains the additional clarification that learning problems may be masked by learned strategies or may not manifest until environmental demands exceed capacities (allowing for consideration of diagnoses at later ages). In contrast to many accepted definitions of a learning disability, DSM-5 does not refer to weaknesses in cognitive processing measures (e.g. working memory, processing speed). In fact, the current criteria do not require the administration of intelligence tests in all situations (average intellectual functioning may be assumed). A learning disorder may now be diagnosed in gifted

individuals and lower cognitive functioning populations, although there is a minimum IQ threshold of 65 (70 ± 5). The DSM-5 definition also distinguishes mild, moderate, and severe versions of the disorder, and speaks to the kind of support required at each level (e.g., "*intensive individualized and specialized teaching"*). This language could pressure the school system to provide a certain intensity or type of service; most school districts will not be comfortable with DSM advising them how to program for students. Finally, the determination of severity level may have implications for access to disability supports (e.g., if a lower level is used by the psychologist, then CRA may deny an application for the disability tax credit).

Suggestions for Practice

Over the years, provincial departments of education have accepted varying definitions of learning disability for the purposes of identification and support (Kozey & Siegel, 2008); however, the Learning Disability Association of Canada (LDAC) definition (2002) has been accepted by most provincial departments of education across the country. None of the existing definitions match the current DSM-5 criteria. Fortunately, a clear distinction can be made between the two models if one examines the terminology used by DSM-5. Although lobbying efforts pressed for adoption of the term *"Learning Disability"*, in the end, DSM landed on the term Learning Disorder, which allows psychologist to distinguish between the two frameworks. In order to support psychologists as they work through questions surrounding the new framework, the LDAC convened an expert panel that prepared a position paper comparing the two models (LDAC, 2015). It is recommended that psychologists work with their school districts to determine which frameworks and criterion sets are most meaningful for their context, and then work to communicate that understanding across the system to reduce potential confusion in the front lines. In order to further reduce misunderstanding, it is recommended that psychologists not use the acronym LD or SLD if referring to a DSM-5 diagnosis of Specific Learning Disorder. School systems that decide to not use IQ testing in all cases may free up service time so that psychologists can focus on conducting functional educational assessments or monitoring individual response to trial interventions, reserving formal assessment for individuals who do not respond to more targeted interventions. To be responsible, such a system must devise ways to monitor students to reduce the chance of missed diagnoses (e.g., gifted LD).

Conclusions

Ultimately, school divisions must consider whether they wish to utilize the DSM-5 diagnostic criteria when conducting their assessments. It may help to know that Alberta education does not require the use of DSM when formally identifying and programming for students with an identified need:

> *The…DSM-5 has been considered in the updates to Special Education Coding Criteria 2014/2015. However, Special Education Coding Criteria 2014/2015 is not intended to provide diagnostic criteria for clinicians but rather to provide educators with information to help identify and program for students/ECS children with an identified need.* (2015)

Ultimately, no matter what decision a school district may reach about its methods of identifying and programming for students with intellectual and learning disabilities, it must take into consideration the needs of students who are leaving their system. Students with intellectual disabilities may require specific documentation in order to be eligible for services, while those who are leaving high school to enter post-secondary institutions may find that the documentation requirements of their receiving institution differ from the district's practices. It behooves school districts to be familiar with the requirements of the most common provincial institutions that their students will be transitioning to upon graduation, and to work with those institutions to ensure that their graduates' needs are recognized. Human rights legislation informs this perspective, although it remains silent on the matter of DSM-5.

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