Viewpoint

BORDERLINE INTELLIGENCE, DISABILITY PROVISIONS AND FUZZY BORDERS

Smitha Ramadas[1]*
[1]Government Medical College, Thrissur, Kerala
*Corresponding address: Additional Professor, Department of Psychiatry, Government Medical College, M.G. Kavu, Thrissur-680596, Kerala, India. Email; dr.smitharamadas@gmail.com

ABSTRACT
The diagnosis and boundaries of borderline intellectual functioning (BIF) lack clarity. The nosological status in DSM 5 and ICD 10 and 11 are also dubious. The provision of 'borderline disability' of 25 % for the category of Intellectual Disability, in the RPWD (Rights of persons with disability) act, falls below the benchmark disability criteria. The Kerala State commissioner for persons with disabilities categorises those with IQ between 70 and 84, as 'borderline intelligent' and provides the benefits of scribe/interpreter to them. Can the psychiatrist certify an entity which does not exist in the current classificatory systems? The author tries to highlight the fallacies in the implementation of disability provisions in Kerala for students with BIF and provides alternative solutions vis a vis the disability plea.
Keywords: borderline intelligence, disability

What are the challenges in the diagnosis of borderline intellectual functioning and service provisions? The term borderline intellectual functioning (BIF), which was previously used to describe individuals with a full-scale IQ in the range of 70 to 84, is no more a diagnostic category under DSM 5. It has been mentioned in DSM-5 in the section "Other Conditions that may be a Focus of Clinical Attention". [1]In ICD 10 and 11 also, there is no such diagnostic entity. It is considered as a condition requiring early intervention in ICD 11[2] and not a disorder. Though people with BIF are at a higher risk than individuals with normal IQ to develop mental health and academic problems[3], not all of them have difficulties with adaptive behaviour or require support[4]. Can the psychiatrist certify a disorder which does not exist either in DSM 5 or ICD 10 or 11? Moreover, intelligence is normally distributed in the population, and wherever the cut off for disability is placed, there are always individuals who fall just below the cut-off and miss the disability benefits.

Access the article online:
https://kjponline.com/index.php/kjp/article/view/203
DOI: https://doi.org/10.30834/KJP.33.2.2020.203
Received:16/6/2020. Web publication:3/8/2020

QR Code

As per the Rights of persons with disabilities (RPWD) act,[5] when the Vineland Social Maturity Scale (VSMS) score is between 70 and 84, the beneficiaries get a disability of 25%. The cut off for IQ is not specified (concurring with the DSM 5 guidelines). Is the diagnosis of the above condition then borderline intelligence with a disability of 25%, or intellectual disability (ID) with borderline adaptive functioning with a disability of 25%, considering both intellectual and adaptive functioning as the guiding criteria for the diagnosis of ID? It falls below the benchmark disability of 40% also, precluding them from disability services. What then is the use of such a provision?

The Kerala State commissioner for persons with disabilities, state that those with IQ between 70 and 84, should be categorised as borderline intelligent and benefits of scribe/interpreter be given to them.[6] What are the concerns in these benefits given for students with BIF?

How to cite the article: Ramdas S. Borderline intelligence, disability provisions and fuzzy borders. (Viewpoint). Kerala Journal of Psychiatry 2020, 33(2):173-175

Students with BIF are given the provision of scribe/interpreter during an examination. Is there a scientific rationale in doing so, if the child does not have specific learning disorder (SLD)?

What is the motive behind these children crowding the psychiatry OP for certification, just a few months before the final examination, pressured by the school authorities? In a study conducted in a tertiary care centre in Kerala, it was found that majority of children who seek certification for scholastic backwardness was slow learners (IQ between 71 and 89).[7] Most of them(60%) were from high school and 80 % of the high school students were attending for their first ever assessment of SB. [7]

Nevertheless, these children deserve attention and assistance, beginning from the early years. Certain suggestions are given below.

1. From a medical point of view, students with poor scholastic performance need to have a provision for availing mental health services. Several models can be postulated. One model which is feasible in Kerala is the stepped care model. The class teacher initially identifies children with academic difficulties, does a preliminary evaluation and then refers to the school counsellor. The counsellor evaluates and provides services. Problems which cannot be handled at the school level shall be referred to psychiatrists. The psychiatrist evaluates, incorporating the services of other mental health professionals and medical specialists and plans management. There should be a feedback policy and liaising with school authorities. The results of such comprehensive evaluation can be incorporated to individualise the child's curriculum, learning and overall development Regular training to school teachers and school counsellors needs to be done to equip them with the necessary knowledge and skills. There are several school mental health programs run by several agencies from different government sectors in a parallel manner in the state.[8] These can be coordinated and streamlined to address the academic, mental health and psychosocial well-being of children.

2. From a pedagogical point of view, an educational approach should also be adopted simultaneously. Students who perform poorly can be identified early either by the class teacher or the special education teacher and can be assessed for their strengths, abilities, and aptitude. The concept of multiple intelligences by Gardener[9] needs to be adopted in schools. Educational authorities need to design curricula with various levels of difficulty and a wider choice of subjects to cater to the differing needs of children. A flexible educational approach with lower curricular load and simplified assessment system may be planned. Alternative education systems and open schools need to be considered. Choice of omission of subjects, electives, peer mentoring, differentiated instruction[10] and functional academics are helpful strategies. A 'one size fits all curriculum' and assessment system are not suitable for them. Burdening students with BIF with a curriculum beyond their intellectual capacity adds to their stress levels and may precipitate mental health problems, for which they are more vulnerable. The principle of equity is being compromised here. Rather than the quest for disability labelling, we need to explore and enrich their abilities. Unnecessary disability labels may also inadvertently lower the expectations from the child and may contribute to stigma.

The system of scribes and interpreters as practised in our educational system since long needs to be viewed with scepticism. Scribes write the exam, contributing their intellectual content in lieu of students with intellectual disability (ID). Students with intellectual disability, passing the exams scoring higher marks than the usual students is not uncommon.[7]In the quest of getting a centum pass in schools and the desire of parents to see their children passing 10th standard by hook or by crook, an illogical and unscrupulous system thrives in Kerala. Do we need to be part of this system?

3. When the entire educational system is transforming into an online mode, cannot the same services and gadgets be used for teaching, learning and assessment of children with learning difficulties? Smart and appropriate use of technology can replace the manual scribes and interpreters and their purported misuse. A fair and equitable educational system is the need of the hour, for the well-being of students.

Financial support and sponsorship:
None.
Conflict of interest:
None declared.

REFERENCES

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.
2. World Health Organization. International Statistical Classification of Diseases and Related Health Problems (11th Revision). 2018. https://icd.who.int/en. Accessed 21 Nov 2019. [last accessed 1-8-2020]
3. Emerson E, Einfeld S, Stancliffe RJ. The mental health of young children with intellectual disabilities or borderline intellectual functioning. Soc Psychiatry Psychiatr Epidemiol. 2010;45:579–87
4. Peltopuro M, Ahonen T, Kaartinen J, Seppälä H, Närhi V. Borderline intellectual functioning: a systematic literature review. Intellect Dev Disabil. 2014;52:419-43
5. Guidelines for Assessment of Disabilities – Gazette; 5 January 2018. Available from: https://thedispatchondisability.files.wordpress.com/2018/01/guidelines-for-assessment-of-various-disabilities-under-rpwd-act-2016.pdf. [Last accessed on 2020 June 12]
6. State Commissioner and Government secretary (2020). Court of State Commissioner for persons with disabilities, No.448/S2/20/SCPWD dated 14-2-2020, Thiruvanathapuram.
7. Ramadas S, Vijayan VV. Profile of students referred for the assessment of scholastic backwardness at a tertiary care center. Indian J Psychiatry 2019;61:439-43
8. Ramkumar GS. Mental health provisions in schools of Kerala: a narrative overview of programs and interventions. Kerala Journal of Psychiatry 2015;28:82-93.
9. Gardner, H. Intelligence reframed: Multiple intelligences for the 21st century. New York: Basic Books;1999.
10. Tomlinson C, Brighton C, Hertberg H, Callahan C, Moon T, Brimijoin K, et al. Differentiating Instruction in Response to Student Readiness, Interest, and Learning Profile in Academically Diverse Classrooms: A Review of Literature. J Educ Gift. 2003;27:119–45.