IS THE CONCEPT OF 'MENTAL RETARDATION' APT?—A CRITICAL DISCUSSION

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A Word on Categorisation as Introduction

Categorisation has evolved from the models of psychopathology. However, the concept of categorisation had more contacts with the medical model rather than with the other models. In the medical model the labelling of deviant behaviour is termed diagnosis and till 1960, it almost appeared a fashion to label behavioral variations separately and to characterise them. The categorisation process has done predominant havoc in the field of psychology. It is very true that the categorisation process and/or the medical model brought in certain amount of reformation. However, it may not be wise to say that since it has brought in reformation, it is an effective model and/or procedure. Recent empirical investigations are making obvious the statement that the medical model is inefficient in explaining behavioral disorders. We will now examine the truthfulness of this statement with reference to 'Mental Retardation'.

From 1900 to 1920 Binet dominated the field of child development with interest centered on classification and psychometry. During that period the presumed 'lower level of intelligence' was termed 'Mental Retardation'. After this the interest of the child psychologists was in growth studies and the interest was expressed in terms of so called 'Normal Growth' and 'Mental Retardation' was of peripheral interest. Under these circumstances the 'low level of intelligence' concept of retardation was not disturbed (Wortis, 1970). However, the proponents of this categorisation have severely been criticised for their stand on the following lines. What they have forgotten is that classifying several individuals into one group because of some similarities will obscure the many important differences. The aim of categorisation is classifying or labelling rather than understanding and modifying the patient's behavior. It also creates the impression for the user that just because he has a name he has understood it and knows all about that. Added to these problems is that no two persons behavior are the same and categorisation permits us to equate two or more people as equal and identical In the categorisation process there will be no 'inner silence' as Korzybski calls it and the clinician's evaluation will be biased because of his implicit assumption of categorisation.

A word does not say everything about anything. Above all categorisation misleads the clinicians. We frequently hear therapists exclamate 'oh! he is an "MR", after all what can he learn'. Thus it creates unwarranted limitations on **what** might be achieved with so called 'Mental Retardates'. This argument

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does not actually say anything about the aptness or otherwise of the term 'Mental Retardation' but tackles a more basic issue.

With this preamble, before embarking upon the aptness or otherwise of the term 'Mental Retardation', it is worthwhile to have a critical examination of the definitions of 'Mental Retardation'.

In science, the most fundamental level of a phenomenon is the definition of it. 'Mental Retardation has been traditionally defined as follows:

(1) 'The mentally retarded individuals, who as a result of inadequately developed intelligence, are significantly impaired in their ability to learn and adapt to the demands of the society' (President's panel on Mental Retardation, 1962).

(2) 'Mental Retardation refers to subaverage general intellectual functioning, which originates during, the developmental period and is associated with the impairment of adaptive behavior' (AAMD, 1961).

(3) Doll includes six criteria which he considers essential for an acceptable concept of retardation. (1) Social incompetence (2) Due to mental subnormality. (3) Which has been developmentally arrested. (4) Which is obtained at maturity. (5) Is of constitutional origin and (6) Which is essentially incurable.

In general the term 'Mental Retardation' is a simple designation for a group ofcomplexphenomenonstemmingfrom many different causes, but the one common factor found in these definitions is that they all emphasize the presumably inadequately developed intelligence. The proponents of this idea argue that intelligence is a constant and basic feature and without a radical effect on the sphere of intelligence the child cannot be considered mentally defective, no matter how ignorant and illiterate he may be or abnormal in his emotional, instinctive, volitional or more relations.

But this seems not to be true. Retardation should only mean 'a limited repertoire of behavior'. For example, if an individual 'A' has 'XYZ' behaviors and individual 'B' has only 'XY' behaviors, the individual 'B' is definitely said to be retarded. On the other hand one cannot say that the behavior 'X' is important and hence as the individual 'B' possesses it, he is not retarded.

Another factor which has been emphasized in these definitions is that the condition is essentially incurable and unremediable through treatment except as training instills habits which superficially or temporarily compensates for the limitations of the person so affected. However, a simple objection at this level is that the term incurable has not been defined. Based on the result of many studies and our clinical experience we can say that the so called 'Mental Retardates' will show improvement after treatment. It is evident further through these investigations that the improvement seen are not compensatory actions but are

actual improvements in tke present behaviors and that these changes are 'fairly' permanent.

The proponents who consider that 'Mental Retardation' exists from birth or early age have not been able to explain why there were greater changes in the rate of growth, the greater the changes were made in the environment (Blatt, 1971). However, they give an answer that such changes are more likely due to errors in original diagnosis. But this it nothing but begging the intriguing questions.

The contention that 'Mental Retardation' is of hereditary nature is based on the administration of routine intelligence tests. Hence we are not justified to say so, till we understand the nature of the human genetics and intelligence and that in any case this is possible only when we go beyond just speculations and bias (Blatt, 1971).

Those who contend that it is a physical or constitutional defect argue that 'Mental Retardation' is a symptom of some constitutional defect. But a review of literature on this shows that 'Mental Retardates' do not exhibit any deficiencies of brain structure or somatic organization (Blatt, 1971). Sarason and Gladwin (1958) sum up that the retarded do not exhibit any central nervous system pathology. Though the validity of these findings is not known, but still such evidence is forthcoming and for any other reasons described here 'Mental Retardation' should be assumed free of constitutional disturbances.

Regarding 'Social Competence' and Impairment of adaptive behavior', these may be due to anything, that is, even the sc called normals exhibit this. What is that which is showing retardation in social behavior in normals? The term a social competence and adaptive behavior have taken into consideration the behaviors which are found commonly and through 'Rating Scales' and 'Questionnaires' they have been quantified. If this is the case, it appears fallacious to talk of 'Impairment of adaptive behavior' in normals. But the point is that adapting to the environment comes more as the individual moves with the society than anything. Moreover this term 'impairment of adaptive behavior' has not been properly defined in the sense that it reflects either can delay in maturation, or a delay in gaining or learning knowledge from his experience and social maladjustment—ability of an individual to sustain himself in a manner consistent with the standards and requirements of the society. But, what happens when an individual changes to a new society! People with introverted characteristics or tendencies will certainly feel it difficult to adjust to a new society. This doctrine explains that all individuals adapt to the new society, however, difference is seen in terms of latency or time taken by the individual to adapt to the new environment. This poses many questions, however, it is quite possible. But empirically we do not know how true it is. The crux of the matter is that an individual who has an IQ of 75 or 80 and who reveals no significant impairment in adaptive behavior is not labelled 'mentally retarded' (AAMD Manual, 1961). However, it is not the contention of the author here to bring a correlation between the IQ and the social

competence nor to say that social criterion is not essential. One important limitation of the IQ approach by Tredgold and others is that IQ approach either overestimates or underestimates the problems. Hence social criterion is essential but the focus should not be only on the social criterion.

Some people claim that social competence reflects intelligence. Considering this we will be landing in one more problem, that is, we do not know the nature of intelligence, precisely. We can't take intelligence as what an intelligence test measures. However, we know that intelligence is an hypothetical concept that ultimately refers to the cognitive processes of the individual (Memory, Abstract reasoning, etc.). But we do not know whether intelligence represents a single cognitive process which permeates all other cognitive processes or whether it represents a variety of relatively discrete cognitive processes which can be sampled and then summated to yield an indication of a person's total intelligence. In the words of Ziegler (1968) 'social competence does not inevitably reflect normal intellectual functioning any more than its absence in the emotionally unstable, criminal or the socially misfit reflects intellectual subnormality'. It is much too heterogenous phenomenon and reflects too many non-intellectual factors to be of great value in understanding mental retardation. The basic problem is that the concept of social competence is so laden with value and its definition is so vague that it has little empirical utility'. And further the social criteria are just as arbitrary as the IQ, if not more so, and have not even have the advantage of being based on norms for an entire population (A. M. Clarke, 1958). The problem is that the social competence construct is ambiguous and the measures of it are not available.

One common aspect of all the above definitions and also various approaches to the study of 'Mental Retardation' is that they all emphasize some hypothetical concepts such as social competence, low level intelligence and biological abnormalities such as clinically inferred brain injury. Skinner (1953) says that 'emotions are excellent examples of the fictional causes to which we commonly attribute behavior'. Likewise in 'Mental Retardation' the limited repertoiry of behavior is said to be caused by low intelligence. The 'Mentally Retarded' individual is deficient in overt behavioral instrumental responses and whose function is to control 'what happens', to prevent undesirable happenings and to insure or at least encourage desirable ones and this observed deficiency is due to the fact that he has not been taught. Whether the hypothetical concept of intelligence is inferred from behavior alone or from behavior in combination with stimulating conditions, its level is said to be built in processes such as heredity, familial, constitutional, intrinsic or endogenous factors and modified by determental environmental extrinsic or exogenous factors (Tredgold and Soddy, 1956). Differences in the observed learning rate in any given situation are a joint result of individual differences in elementary capacities and in cumulating results of past learning in the same and other situations. This capacity may be determined either gene-

tically or by some combination of genetic factors and developmental processes which are independent of previous learning.

As man is the product of the biological and social heritage and the capacity and also what to learn is biologically given, in this frame of reference, one should ask the question as to how one is retarded instead of why one is retarded. And so his personality, or his social and other experiences lie outside the scope of the learning theory. Though the congenital mechanisms are necessary for complete understanding of the human personality it is doubtful whether with such knowledge alone one can deduce or predict the development of personality of an individual. Learning makes a man changeable.

In 'Mentally Retarded' individuals there is observed a change in their performance because of inadequate learning or acquiring. But the why of this phenomenon has not been explained by bahaviorists. Differences between normal and retarded groups with respect to previous learning experiences may have important bearing upon the differences observed (Estes, 1970).

Mowrer (1960) refers to this as learning sets or learning to learn. It is well known that learning of language by a human infant opens up for him further learning capacities or at least opportunities. It is also well known that not having learnt a behavior may well influence and interfere in the acquisition of other behaviors. One difficulty of explaining 'Mental Retardation' in hypothetical terms is that, it is common practice to infer causes from the observed behavior, of which we are not justified. If this is the case, then in 'Mental Retardation', low intelligence will be the cause and at no point we make contact with any event outside the behavior which justifies our casual connection. The inefficient performance of the 'Mentally Retarded' in a task reflects to a major extent his retardation in the development of various habits of selective attention, search and rehearsal, coding and recoding of stimulus information. When the task is simplified to reduce the possible contribution of these various auxilliary processes, he performs better. Individual differences in their habit systems may reflect difference in capacities and/or strongly determined by variation in motivation systems and previous opportunities to learn.

But it may be true that the so called 'Mentally Retarded' children will perform better when they are focused to 'ideal' environment. However, Ziegler assumes that the differences between the 'Mentally Retarded' and the normals is not quantitative but qualitative. Behaviorists including Skinner argue that 'mental retardation' is not existing taking into consideration the repertoire of behavior. But Ziegler says that it may be true that the mental retardates behavior repertoire is narrowed because of the non-availability of the environment or reinforcement, but even when these individuals are focused to the normal environment and even when they acquire similar relations as a normal individual and even though they become equal in terms of number of behaviors, they do differ qualitatively. He concludes 'mental retardation is a qualitative disorder rather than a quantitative one'

(Ziegler, 1968). However, Ziegler has been criticised on the following grounds. It appears that many of the differences between retardates and normals of the same mental age are a result of motivational and emotional differences which reflect differences in environmental histories and not in innate capacities.

A normal child learns discriminations, to respond differently to different stimuli and so he gets the maximum reward and this generalises to new situations. This type of correct scanning of different responses are conspicuously absent in 'mentally retarded', whom are termed 'impulsive', 'distractable' etc. This lack of ability to scan responses is attributed to localised brain lesion but these defects are largely a result of absence of necessary conditions for learning the habits of stimulus scanning and inability to learn. Unless these are learnt the question of generalization is beyond the scope.

For the development of any behavior motivation is necessary and for normal motivational development an environment relatively free of punishment is important. However, with the 'Mentally Retarded' this reinforcement paradigm is not proper because it is a vicious circle here. Estes (1970) states that none of the retention or learning processes that have been analysed in normal human behaviour in the laboratory differ qualitatively in the mentally defective. The reader is referred to Bijou in Ellis (1966) who has extensively dealt with this. Bijou (1966) stresses, that, in 'Mental Retardation' the main object should be to analyse the observable conditions which produce retarded behaviour and not retarded mentality. The concept of IQ or intelligence does not serve any important rehabilitative interest in the retardates.

We have seen so far, that in 'Mental Retardation', intelligence is the prime factor and it has been given the utmost importance, so that some clinician's find it shocking even to imagine any other approach to the study of this condition, we know many disadvantages of the concept of IQ and of intelligence tests. Though yet the main tool of clinicians in the diagnosis and classification of retardates is intelligence test.

The ratio of the mental age over the chronological age (usually multiplied by 100 to get rid of the decimal point) is referred to as IQ. This concept of IQ has got many disadvantages. This IQ does not remain constant and this consistency is essential to make any prediction about the child. There are research reports which have dispelled the norms showing that the IQ varied with the type of test administered, maturation and experience, emotional stability and education. And Eyesenck (1960) says that IQ's obtained before the age of six are of very little use and hence a diagnosis of retardation based on this criteria, before the age of six years becomes totally invalid. However, granted that IQ's are reasonably constant then it will be again a problem in determining the IQ's of older children and adults. The growth and decline of the mental ability with age has been studied by many and from this we know that the growth of intelligence is reasonably linear only between the ages 6 and 12 and it follows from this that we cannot properly

calculate the IQ beyond the age of 12 or 15 at the most. However, it is possible in this purely statistical world. The concept of intelligence has been thoroughly misguided by the test constructors and the psychometricians.

The validity of the IQ should also be questioned at this stage. The prediction of an individual's IQ just based on intelligence tests has many disadvantages. To start with, these tests do not consider the individual's special abilities, and interests. So the IQ is just the average of his performance in different tasks. They do not take the effect of practice and coaching, his motivation and anxiety, his physical and or psychological conditions. And the administration of intelligence tests has also got many disadvantages. We ordinarily do it this way: we look at the profiles; we call to mind, what the various test dimensions mean for dynamics; we reflect on other patients we have seen with similar patterns; we think of the research literature; then we combine these considerations to make inferences (Corah, 1971). Our aim is just to have seme quantitative data.

To conclude, viewing 'Mental Retardation' as low level intelligence does not serve any rehabilitative purpose. It is better, if the retarded development is viewed as a function of inadequate reinforcement and discriminative histories. Inadequate performance, whether in daily life situations, or in intelligence tests or in any other situation should be viewed as, that appropriate behaviours have not been selectively strengthened by differential reinforcement in the past. IQ is a very poor predictor (Eyesenck, 1970).

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