

# MENTAL RETARDATION (MR)

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## MENTAL RETARDATION (MR)

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### 1. Core Definition

The concept of **Mental Retardation (MR)**, a term historically used within clinical and academic settings, refers to a disorder characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. Crucially, these limitations must originate before the age of 18, during the developmental period. While the term *Mental Retardation* was standardized in previous editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and the International Classification of Diseases (ICD-10), it has largely been superseded by the less stigmatizing and more descriptive terminology of **Intellectual Developmental Disorder (IDD)** or **Intellectual Disability (ID)** in modern nosology, specifically within the DSM-5 and ICD-11 classifications.

The official diagnostic criteria historically centered on psychometric assessment, establishing a threshold of intellectual function significantly below the population average. Specifically, an individual was classified as having MR if they exhibited a measured Intelligence Quotient (IQ) of 70 or below. This score represents approximately two standard deviations below the mean IQ of 100 on standardized intelligence tests, which typically possess a standard deviation of 15. The emphasis on the 70-point cutoff was not absolute; clinical judgment always mandated that the diagnosis required concurrent deficits in adaptive functioning. Therefore, a low IQ score alone was insufficient for diagnosis; the individual also had to demonstrate difficulties mastering conceptual, social, and practical skills required for independent living.

The definition mandates a profound distinction between **Intellectual Disability** and specific learning disorders or temporary cognitive impairments. Intellectual Disability is characterized by pervasive and long-term limitations that affect global cognitive processing and the ability to learn and adapt across multiple environments. The early onset during the developmental period is essential for classification, differentiating this condition from cognitive decline acquired later in life due to injury, illness, or neurodegenerative disorders. Understanding this core definition is vital for appropriate intervention planning, educational placement, and accessing essential support services throughout the lifespan.

### 2. Etymology and Historical Development

The history of classifying and describing individuals with cognitive limitations is marked by shifting terminology and evolving societal attitudes, often reflecting stigma and misunderstanding. In the 19th and early 20th centuries, archaic and highly offensive terms such as **idiocy**, **imbecility**, and

**feeble-mindedness** were used to categorize individuals based on perceived severity of cognitive impairment. These terms were often linked to moral judgments rather than medical or psychological understanding, leading to widespread institutionalization and neglect. The categorization was crude, relying primarily on observable developmental milestones and functional capacity rather than standardized testing.

The formalization of the term **Mental Retardation (MR)** began to take hold in the mid-20th century, particularly following the widespread adoption of standardized IQ testing, spearheaded by figures like Alfred Binet. This shift represented a move toward a more scientific, albeit still reductive, quantification of intellect. Organizations like the American Association on Intellectual and Developmental Disabilities (AAIDD), formerly the American Association on Mental Deficiency (AAMD), played a key role in developing multi-axial systems that attempted to define MR not just by IQ but also by adaptive behavior deficits. This represented a crucial step away from purely deficit-based labeling toward a model that considered an individual's ability to function effectively in society.

The transition from MR to **Intellectual Disability (ID)** in the 21st century reflects a global effort to adopt language that emphasizes dignity, respect, and inherent human worth. The change was formally adopted in the DSM-5 (2013) and subsequently by most major international health and disability organizations. The primary impetus for this change was the recognition that the term "retardation" had become deeply pejorative, synonymous with insult, thereby contributing to the social marginalization of affected individuals and their families. While the core diagnostic criteria--significant deficits in intellectual functioning and adaptive behavior--remained largely consistent, the new terminology focuses on the functional limitations inherent in the disability rather than a perceived permanent state of delayed development.

### 3. Key Characteristics and Diagnostic Criteria

Contemporary diagnosis, regardless of the historical term used, relies on three core criteria that must be met for an individual to be classified as having Intellectual Disability. These criteria ensure that the diagnosis captures a true developmental disorder affecting global functioning, rather than specific learning difficulties or psychosocial problems. The diagnosis requires evidence from multiple sources, including standardized testing, detailed history taking, and observation across various settings (e.g., home, school, community).

The first criterion is significant deficits in **intellectual functioning**. This is primarily assessed through standardized, individually administered intelligence tests. Scores must be approximately two standard deviations or more below the population mean (i.e., IQ 70 or below, allowing for a 5-point margin of error to account for test variability). Intellectual functions encompass reasoning, problem-solving, planning, abstract thinking, judgment, learning from instruction, and experiential

learning. These deficits must be confirmed by clinical assessment, ensuring that the test results are reliable given the individual's cultural background and communicative abilities.

The second, equally critical criterion is significant deficits in **adaptive functioning**. Adaptive behavior refers to how well a person handles common life demands and meets the standards of personal independence and social responsibility expected for their age and cultural group. Adaptive skills are generally grouped into three domains:

**Conceptual Skills:** Including literacy, self-direction, time and number concepts, and receptive/expressive language.

**Social Skills:** Covering interpersonal skills, social problem-solving, responsibility, self-esteem, gullibility, and the ability to follow rules and avoid victimization.

**Practical Skills:** Encompassing activities of daily living (ADLs), occupational skills, healthcare, travel/transportation, use of money, and safety.

The third criterion dictates that the onset of these intellectual and adaptive deficits must occur during the **developmental period**, typically defined as before the individual reaches 18 years of age. This stipulation is crucial for differential diagnosis, separating Intellectual Disability from other conditions such as neurocognitive disorders (dementia) or traumatic brain injury, which occur later in life after typical cognitive development has been completed. The simultaneous presence of deficits in intellectual function and adaptive behavior, combined with early onset, forms the enduring basis of the diagnosis.

#### 4. Classification of Severity

Historically, Mental Retardation was classified into severity levels based almost exclusively on the measured IQ score. Modern practice, particularly since the DSM-5, emphasizes the level of support needed, defined by the degree of impairment in adaptive functioning, rather than solely relying on the IQ score, although IQ remains an important indicator. The classifications are typically divided into four levels: mild, moderate, severe, and profound.

**Mild Intellectual Disability:** Constitutes the largest percentage of cases (around 85%). Individuals typically have IQ scores ranging from 50-55 to approximately 70. They often achieve academic skills up to a 6th-grade level, can live independently with minimal supports, and often hold semi-skilled or unskilled jobs. Difficulties often appear primarily in complex conceptual tasks.

**Moderate Intellectual Disability:** IQ scores generally range from 35-40 to 50-55. Individuals require more extensive support in academic and vocational settings. They can typically perform simple tasks under supervision, develop meaningful relationships, and achieve a certain level of self-management, but require structured living environments and assistance with daily decision-making and transportation.

**Severe Intellectual Disability:** IQ scores range from 20-25 to 35-40. Individuals usually have little

or no conceptual understanding of written language or numbers. They require extensive support across all domains, and while they can acquire some self-care skills, they need daily supervision and often communicate through simple phrases or non-verbal means.

**Profound Intellectual Disability:** IQ scores fall below 20-25. Individuals require comprehensive and continuous support for all activities of daily living and medical care. They typically have highly limited communication abilities and often have co-occurring medical conditions and physical impairments. Interventions focus on maximizing sensory enjoyment and communication via the simplest means.

This classification system assists clinicians and educators in tailoring the necessary intensity of supports, ranging from intermittent assistance to pervasive, life-long support. The focus has shifted from labeling based on IQ to designing individualized support plans (ISPs) that maximize the individual's potential for autonomy and inclusion in the community.

## 5. Significance and Impact

The diagnosis of Intellectual Disability has profound significance, impacting every facet of an individual's life, from educational opportunities to long-term health and social integration. Early and accurate diagnosis is critical, as it unlocks access to specialized resources essential for optimizing developmental outcomes. These resources typically include early intervention programs, specialized therapy (speech, occupational, physical), and crucial family support services designed to teach adaptive strategies.

In the educational system, the diagnosis triggers mandates for specialized education under acts such as the Individuals with Disabilities Education Act (IDEA) in the United States. This guarantees the provision of a Free Appropriate Public Education (FAPE) and the development of an Individualized Education Program (IEP) tailored to the student's specific cognitive and adaptive needs. The goal is no longer simply academic remediation but fostering functional skills that promote independence and successful transition into adult community life.

On a societal level, the prevalence of Intellectual Disability--estimated to affect 1% to 3% of the global population--necessitates robust public health and social welfare policies. These policies address housing, vocational rehabilitation, employment programs (often supported or sheltered employment), and the prevention of abuse and exploitation, to which this population is particularly vulnerable. The shift in terminology and the focus on supports underscores the goal of full inclusion, ensuring that individuals with IDD are afforded the same rights and opportunities as their non-disabled peers.

## 6. Debates and Criticisms

Despite advancements in understanding and support, the field surrounding Intellectual Disability

remains subject to considerable debate and criticism, particularly concerning diagnostic methodology and societal response. One major historical criticism centers on the reliance on the **IQ metric**. Critics argue that standardized IQ tests may not accurately capture an individual's full range of intelligence, especially creativity, practical knowledge, and emotional intelligence. Furthermore, these tests have been historically criticized for cultural and linguistic bias, potentially leading to the over-diagnosis of minority or low socioeconomic status populations.

A second significant area of debate involves the ethics of the diagnostic label itself. While the shift from *Mental Retardation* to *Intellectual Disability* was a crucial step to reduce stigma, any formal diagnosis carries the risk of labeling, which can affect self-perception, peer interactions, and opportunities. Advocacy groups stress the importance of person-first language and emphasize the need to view the condition as a difference in cognitive processing that requires specific supports, rather than a fundamental deficiency in character or potential.

Finally, there are ongoing debates regarding service provision and resource allocation. Despite federal mandates, many systems struggle to provide the high-quality, continuous, and individualized support necessary for individuals with severe and profound IDD. The deinstitutionalization movement, while ethically necessary, placed significant pressure on community-based services, leading to uneven quality of care and persistent challenges related to housing, meaningful employment, and mental health services for this population. These debates drive ongoing research into more accurate assessment tools and more effective, person-centered support models.

## Further Reading

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).

American Association on Intellectual and Developmental Disabilities (AAIDD)

Centers for Disease Control and Prevention (CDC). Intellectual Disability.

Wikipedia. Intellectual disability.