

Mental Retardation

Authored by
mohammad looti

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Primary Disciplinary Field(s): Psychology, Psychiatry, Education, Developmental Medicine, Public Health

1. Core Definition

Historically, **Mental Retardation** was a widely used clinical and legal term referring to a significant subaverage general intellectual functioning, accompanied by concurrent deficits in adaptive behavior, which manifested during the developmental period. The primary source content succinctly outlines this by stating that a person with mental retardation "scores below 70 on an intelligence test and, as such, has limited mental abilities." This numerical threshold, typically an Intelligence Quotient (IQ) score of 70 or below on standardized tests, served as a primary diagnostic criterion, indicating a significant deviation from the average intellectual capacity of the general population.

Beyond the psychometric measure, the definition crucially included considerable challenges in adapting to the demands of everyday life. The source emphasizes "difficulty dealing with day-day aspects of living," which encompasses a broad spectrum of adaptive skills. These skills are generally categorized into conceptual, social, and practical domains. Conceptual skills include language, literacy, money, time, and number concepts; social skills involve interpersonal skills, social responsibility, self-esteem, gullibility, naiveté, social problem-solving, and the ability to follow rules and avoid victimization; practical skills include activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, and use of money. The simultaneous presence of both intellectual deficits and significant limitations in adaptive functioning was essential for a formal diagnosis.

It is important to note that the term implied a condition that originated before the age of 18, during the developmental period, differentiating it from cognitive declines that might occur later in life due to injury, disease, or aging. The diagnostic criteria, as articulated by organizations like the American Association on Intellectual and Developmental Disabilities (AAIDD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), underscored this developmental onset and the need for impairment across multiple life areas. The understanding was that these limitations presented ongoing challenges requiring varying degrees of support throughout an individual's lifespan.

2. Etymology and Historical Development

The term **Mental Retardation** has a complex and often troubling history, reflecting evolving societal attitudes and scientific understanding of cognitive differences. Its etymology stems from Latin roots: "mens" meaning mind, and "retardare" meaning to slow or impede. In the English

language, "retard" initially meant to delay or impede and was used in medical contexts in the mid-19th century to describe conditions of delayed mental development. For instance, the term "mentally retarded" gained clinical traction in the early 20th century, replacing older, often more pejorative terms such as "idiot," "imbecile," and "moron," which were themselves clinical classifications based on IQ levels (e.g., idiot for IQ below 20, imbecile for 20-49, moron for 50-69).

Throughout much of the 20th century, **Mental Retardation** became the standard diagnostic term in medical, psychological, and educational fields across the English-speaking world. It was used in widely influential diagnostic manuals such as the various editions of the DSM (Diagnostic and Statistical Manual of Mental Disorders) until its fourth revised edition (DSM-IV-TR) and in the International Classification of Diseases (ICD) until its tenth revision (ICD-10). These classifications provided a standardized framework for diagnosis, research, and resource allocation. However, despite its clinical utility, the term increasingly acquired negative connotations in everyday language, becoming synonymous with derogatory insults.

Recognizing the stigmatizing impact and the desire for more person-first, respectful language, a significant shift in terminology began in the late 20th and early 21st centuries. The source content acknowledges this evolution, stating, "As we have become much more politically correct, this term is used less frequently and has been somewhat replaced by the term 'mentally challenged'." This societal and professional pressure led to a formal renaming. In 2007, the AAIDD officially adopted the term **Intellectual Disability** to replace Mental Retardation. This change was subsequently incorporated into the DSM-5 (2013) and is widely accepted in most academic, clinical, and policy contexts today. The ICD-11 (published 2018, effective 2022) also uses "Disorders of intellectual development." The shift reflects a broader understanding that the condition refers to a functional limitation rather than an inherent flaw, emphasizing the need for support and recognizing the individual's personhood.

3. Key Characteristics

The defining characteristic of **Mental Retardation**, now more appropriately referred to as **Intellectual Disability**, is a significantly impaired intellectual functioning, which the source identifies as an IQ score below 70. This intellectual deficit is not merely a quantitative measure but manifests in challenges across various cognitive domains. Individuals often demonstrate difficulties with abstract thinking, problem-solving, planning, judgment, academic learning, and learning from experience. Their processing speed may be slower, and their ability to generalize learned information to new situations can be limited. These cognitive challenges significantly impact their capacity to acquire knowledge and skills at the same pace as their peers.

Complementing the intellectual limitations are significant deficits in **adaptive functioning**. The source highlights "limited mental capabilities, and difficulty dealing with day-day-day aspects of

living." These adaptive impairments are crucial for diagnosis and describe how well a person handles common life demands and how independent they are compared to others of a similar age and background. Adaptive skills are broadly categorized: **conceptual skills** (e.g., language, reading, writing, money, self-direction), **social skills** (e.g., interpersonal communication, social judgment, friendship skills, self-esteem, following rules), and **practical skills** (e.g., personal care, job skills, money management, navigating public transportation, home/school activities, healthcare, safety). Deficits must be present in at least one of these domains to meet diagnostic criteria.

The source also notes that "There is a range of mental retardation from mild to profound." This spectrum is critical in understanding the diverse needs and support requirements of individuals. **Mild Intellectual Disability** (IQ 50-70) often allows individuals to live independently with minimal support, achieve academic skills up to a sixth-grade level, and hold semi-skilled or unskilled jobs. **Moderate Intellectual Disability** (IQ 35-49) typically requires more significant supervision, vocational training, and supportive living environments, with individuals able to communicate and perform self-care with assistance. **Severe Intellectual Disability** (IQ 20-34) involves substantial support for all daily living activities, limited communication, and often co-occurring physical or sensory impairments. Finally, **Profound Intellectual Disability** (IQ below 20) necessitates round-the-clock care, with individuals having very limited understanding and communication abilities, often requiring extensive medical and nursing support. The level of support required, rather than just the IQ score, is now increasingly emphasized in classification and intervention planning.

4. Significance and Impact

The diagnosis of **Mental Retardation** (now **Intellectual Disability**) carries profound significance for individuals, families, and society, primarily because it serves as a gateway to understanding specific needs and accessing appropriate support services. A formal diagnosis allows for early intervention, which is critical for maximizing developmental potential. Early childhood programs, specialized educational curricula, and therapeutic interventions (such as speech therapy, occupational therapy, and physical therapy) can be tailored to address specific areas of deficit, foster skill development, and promote greater independence. Without such a diagnosis, individuals might struggle without appropriate accommodations, leading to frustration, learned helplessness, and missed opportunities for growth.

For families, the diagnosis provides a framework for understanding their loved one's challenges, connecting with support networks, and navigating complex healthcare and educational systems. It enables families to advocate for necessary resources, including respite care, financial assistance, and specialized residential options. The impact extends to societal planning, influencing public health initiatives, educational policies, and social welfare programs. Recognition of intellectual disability has led to the development of inclusive education models, vocational training programs, and employment support initiatives aimed at integrating individuals into the community and

workplace to the fullest extent possible. Legislation, such as the Americans with Disabilities Act (ADA) in the United States, has been instrumental in ensuring rights and protections for individuals with intellectual disabilities, prohibiting discrimination and mandating reasonable accommodations.

Furthermore, understanding **Intellectual Disability** has advanced research into its causes, which can be diverse and include genetic conditions (e.g., Down syndrome, Fragile X syndrome), prenatal factors (e.g., maternal infections, exposure to toxins), perinatal complications (e.g., birth asphyxia), and postnatal issues (e.g., traumatic brain injury, severe malnutrition). This research not only informs prevention strategies but also leads to improved interventions and therapies. The shift in terminology and understanding also impacts public perception, moving away from a deficit-based model to one that emphasizes individual strengths, capabilities, and the need for environmental supports to facilitate participation and well-being. This person-centered approach aims to enhance the quality of life for individuals with intellectual disabilities, promoting their inclusion and respect within society.

5. Debates and Criticisms

The term **Mental Retardation** has faced significant debate and criticism, primarily due to its increasingly pejorative connotations and the stigmatization it inflicted upon individuals. As the source content briefly touches upon, "As we have become much more politically correct, this term is used less frequently." Over time, "retard" became a common slur, embedding negative stereotypes and devaluing individuals with cognitive differences in mainstream language. This casual misuse in turn profoundly impacted self-esteem, social acceptance, and the perception of those diagnosed with the condition. Advocacy groups, self-advocates, and professional organizations championed a change, arguing that the language used to describe people should reflect dignity and respect, emphasizing the person first, not the disability.

Another major area of criticism revolved around the reliance on IQ tests as the primary diagnostic criterion. While the source notes that a score "below 70 on an intelligence test" is technical, critics have long argued that IQ tests, despite their standardization, do not fully capture the complexity of human intelligence and can be culturally biased. They may not accurately reflect an individual's practical problem-solving abilities, creativity, or social intelligence. Furthermore, a single numerical cutoff risked oversimplifying a highly heterogeneous group of individuals and potentially overlooking those who might have adaptive challenges without falling strictly below the IQ threshold. This led to a stronger emphasis on adaptive functioning as an equally critical component of diagnosis, acknowledging that real-world skills are as important as cognitive scores.

The culmination of these criticisms led to the widespread adoption of **Intellectual Disability** as the preferred and clinically accurate term. This change, embraced by the AAIDD, the DSM-5, and the ICD-11, signifies a paradigm shift. It moves away from a label that implies inherent deficit or blame

to one that describes a functional limitation requiring support. The debate over terminology is not merely semantic; it reflects a deeper philosophical and ethical commitment to person-first language, human rights, and the promotion of inclusion. While the term **Mental Retardation** remains in older legal texts and historical documents, its active use in contemporary clinical and academic discourse is largely deprecated, in favor of language that fosters greater understanding and reduces stigma.

Further Reading

[American Association on Intellectual and Developmental Disabilities \(AAIDD\)](#)

[Diagnostic and Statistical Manual of Mental Disorders \(DSM-5\)](#)

[International Classification of Diseases \(ICD-11\)](#)

[Wikipedia: Intellectual disability](#)

[U.S. Department of Justice: Americans with Disabilities Act \(ADA\)](#)

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