CHAPTER I
MENTAL RETARDATION

TERMINOLOGY

In a general manner the simple term 'learning difficulties' can be used when referring to mental retardation. But from the viewpoint of medical science, psychology and education this term is too general and covers several conditions besides mental retardation. Thus it is inappropriate. As different professional disciplines are involved in the care, education and rehabilitation of those having mental retardation, there are different and too many terms used for referring to the same condition.

In ancient Indian literature terms like 'Jada', 'Buddhimandyam', 'Manasamandyam', 'Mudha Buddhi', 'Manasikadurbalyam' are used for explaining mental retardation (Balodhi, 1985). In present India mental retardation is the commonly used term. In the Hindi language it is referred to as 'Mandabuddhi'. In Maharashtra the term 'Matimanda' is more widely used.

Since the 1800s, in the World literature on this condition, individuals with mental retardation have been referred to by the following terms, Amentic, Children with Special Needs, Children with Severe Learning Difficulties, Exceptional Children, Educationally Subnormals, Feebleminded, Idiots, Imbeciles, Intellectually Disabled, Intellectually Subnormals, Mentally Defective, Mentally Deficient, Mentally Handicapped,

**DEFINITION**

Whichever the term used for referring to the condition the following two characteristics are the essential components of mental retardation.

1. Intellectual functioning which is significantly below average and which has been present from an early age.

2. Marked impairment in the ability to adapt to the cultural demands of society (Cobb 1980).

All the definitions of mental retardation put forward until now refer to either or both of these characteristics. (Please refer Appendix 1(a) for list of definitions)

Only Bijou, as reported by Mittler, differs with the rest in viewing mental retardation. According to his terms such as intelligence or even adaptation are hypothetical constructs and cannot be directly observed. Hence Bijou sees the mentally retarded as someone who has a limited repertoire of behaviours due to limited and unrewarded contact with the environment (Mittler, 1979).

The most comprehensive and hence the most accepted definition is the one adopted by the American Association on Mental Deficiency in 1973.
It states
"Mental retardation refers to significant subaverage general intellectual functioning existing concurrently with deficits in adaptive behaviour and manifested during the developmental period.

Here sub-average General Intellectual Functioning means-Falling below 97% of the population on standardized tests of global intelligence (tests which attempt to measure vocabulary, comprehension, memory, reasoning, judgement and visual-motor functions).

Adaptive Behaviour means-The ability to adapt to and control one's environment, usually defined in terms of maturation, learning and social skills.

Developmental Period -The period from conception to about 16 years of age." (N.A.R.C., 1977).

There is no original definition put forward to define mental retardation from the viewpoint of and in the context of Indian social and cultural factors. The above definition adopted by the American Association on Mental Deficiency is unofficially followed by organizations and individuals working in the field of mental retardation in India. Verma has expressed reservations on this practice of directly accepting the American definition. (Verma, 1986).

CHARACTERISTICS OF MENTAL RETARDATION.
The clinical picture and the characteristics differ according to the type of factor which causes the condition.
Individuals with mental retardation always have a mental age below their chronological age. The majority of them manifest the syndrome of cerebral dysfunction which consists of hyperactivity, short span of attention, distractibility, poor concentration, poor memory, impulsiveness, awkward clumsy movements, disturbed sleep, emotional instability, low frustration tolerance, and wide scatter in intellectual function.

They are relatively adept in some spheres and poor in other spheres being especially poor at arithmetic and abstract concepts.

Associated defects of the musculoskeletal system, of vision and of speech and hearing are often found in the mentally retarded. Congenital anomalies may be associated when the cause is prenatal. Convulsions are a common associated problem.

Some specific types of mental retardation have specific clinical pictures such as Cretinism, Down's Syndrome, mucopolysaccharidoses and Lipidoses.

CLASSIFICATION

The multiplicity of symptoms, the wide scatter in disabilities and variability in the abilities of mentally retarded individuals makes it necessary to classify these individuals into types. Such a necessity became the mother of the invention of the concept of Mental Age.
Later, the concept of Intelligence Quotient—calculated by using the mental age—became the criterion on which the classifications got based. Most systems of classification use the criterion of Intelligence Quotient even now. (Please refer to Appendix 1(b) for list of classification).

FACTORS LEADING TO MENTAL RETARDATION

There are numerous diagnostic conditions in which mental retardation is a feature. The factors causing these conditions too are numerous. (Please refer Appendix 1(c) for list of etiological factors). The factors are reorganized as enumerated below because such a grouping will be relevant in drawing a curriculum of educational intervention. The three categories under which the factors are grouped are;

1. Established factors. Children who are retarded owing to these factors have an aberrant development. The aberration is closely related to the diagnosed medical disorders of known etiology e.g. chromosomal disorders. In conditions caused by these factors mental retardation is an inherent feature of the condition itself. The curriculum for these children focuses more on the motor, perceptual-motor, self-help skills and behaviour training aspects.

2. Environmental factors. Children who are retarded owing to these factors are organically sound. In them mental retardation is the effect of deviant early life experiences e.g. poor physical and social stimulation, insufficient opportunities for practice and expression of
adaptive behaviours, inadequate maternal care and health care. The curriculum for these children focuses more on creating opportunities for cognitive skills learning and for practice and expression of adaptive behaviour.

3. Biological factors. Children who are retarded owing to these factors have an aberrant development. Such development is the result of biological insult(s) to their developing central nervous system. In them mental retardation is the effect of the organic insult(s). The curriculum for these children focuses on motor, perceptual-motor and cognitive-skills training aspects.

One of the etiological factors very pertinent to Indian social system is the factor of consanguinity. Consanguinous marriages are very common in India. In northern India it is 6.3%, but in southern India the percentage of consanguinous marriage is between 45.3% to 47.8%. In southern India in 70% of mentally retarded the parents are observed to have a consanguinous marriage. (Kulkarni, 1979).

PREVALENCE

Mental retardation is a global challenge. According to the estimates of United Nations more than 400 million of the world’s population fall under this category. (Mittler, 1984). This comes to between 2 to 3 percent of the world’s population.
In India the prevalence of mental retardation is evidently present. But whereas there are estimates of number of individuals falling under other categories of disabilities in the National Sample Survey of 1981, mentally retarded individuals have not been counted. An exact estimate of the number of mentally retarded individuals is rather impossible in a country like India. There are several reasons for this to be so.

First of all there is a great variation in India in the methodology of study, definition of mental retardation, criteria on which the diagnosis is based, the type of investigating team, the type and scope of investigations done, and the type of population surveyed. (Sinclair, 1979; Nimbkar, 1980; Prabhu et al, 1985).

Secondly Indian society accepts and absorbs a great many idiosyncrasies. A mentally retarded individual, particularly a child, is accepted and tolerated unless he becomes unmanageable and a social risk. Thus the number of mentally retardeds registered at hospitals or clinics or special schools cannot be taken as a true representation of the actual incidence. (Uday Shankar, 1976; Chacko, 1981; Naik, 1984).

Thirdly in India education is not compulsory for all children. Therefore there is no system in use which has a built-in machinery of observing all the children in their developing stages. Thus detection and identification of mentally retarded children is not systematic. Moreover if at all a school does detect a mentally retarded child there is no laid-down procedure for
referring such a child to special services.

Lastly, in India special services for mentally retarded individuals are appallingly few. It is estimated that together the existing services provide service to only 0.04 to 0.05 percent of the possible mentally retarded population in India. This can be seen as an indication of insufficient awareness regarding the mentally retarded amongst people in general. (Kothawala, 1979; Sinclair, 1979; D'souza, 1984; Krishnamurthy, 1984; Narasimhan, 1985).

Eventhough exact figures about the mentally retarded individuals in India are not available, yet there are estimates proposed by different workers and a few prevalence surveys. But the figures presented by these show great disparity.

The earliest survey quoted mentions that in 1953 the Union Ministry of Education calculated that there were 1.5 million individuals in India who were mentally retarded. But as there is no information given about the method utilised to obtain this figure its validity is not established. (Nimbkar, 1980).

Prabhu and others have studied the various related prevalence surveys conducted between 1968 and 1981. Only those four which surveyed the incidence of mental retardation alone - and not as a part of survey for all types of psychiatric disorders - are reported in Table 1.
### Table 1: Prevalence Studies: Mental Retardation

<table>
<thead>
<tr>
<th>Study Year Place</th>
<th>Urban</th>
<th>No. of Families</th>
<th>No. of Persons Screened</th>
<th>Reported Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verma 1968 Nagpur Urban</td>
<td>4696</td>
<td>30,326</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Gupta &amp; Sethi 1970 Lucknow Urban &amp; Rural</td>
<td>1500</td>
<td>8,585</td>
<td>23.3</td>
<td></td>
</tr>
<tr>
<td>Narayanan 1981 Bangalore Rural</td>
<td>-</td>
<td>13,777</td>
<td>3.4</td>
<td></td>
</tr>
<tr>
<td>Subramanya 1984 Bangalore Rural</td>
<td>-</td>
<td>1,498</td>
<td>27.4</td>
<td></td>
</tr>
</tbody>
</table>

Source: Prabhu, G. et al. Mental Retardation in India. New Delhi: In Souvenir of 7th World Congress of International Association for the Scientific Study of Mental Deficiency, 1985, Page 18.

Three authors have estimated the prevalence after the National Sample Survey of 1981. They state the estimate as follows:

- Desouza (1984) around 15 million
- Naik (1984) between 6.8 million and 20.4 million
- Prabhu (1985) between 13 million and 18 million

Whichever estimate happens to be correct one thing is clear that the number is not small.

Uday Shankar therefore rightly states, "what is essential at present are not so much clear-cut surveys to know mathematically correct figures........ as the need of starting some institutions or agencies to look after some of them, at least" (Uday Shankar, 1976)
Summary

This chapter introduces the topic of mental retardation. It gives the various terminologies, definitions, etiological factors and symptoms or clinical characteristics of mental retardation. It finally gives information regarding the magnanimity of the problem by discussing the matter of prevalence of mental retardation. At significant points reference is made to the information on mental retardation in India.

REFERENCES

Bolodhi, J. Mental Retardation in Ancient Indian Thought. New Delhi: In Souvenir of 7th World Congress of International Association for the Scientific Study of Mental Deficiency, 1985.


