

Mental Retardation”: Attitudes & Terminology

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Historical Context and Origins of the Terminology

The term **Mental Retardation** (MR) emerged in the mid-20th century as a replacement for earlier, often highly pejorative and scientifically inadequate labels such as "idiocy," "imbecility," and "feeble-mindedness." This shift was initially intended to be a progressive, clinical step towards standardization and humane treatment, providing a quantifiable definition based on intelligence quotient (IQ) scores and adaptive functioning deficits. Prior to this standardization, classification systems varied widely, leading to inconsistencies in diagnosis, education, and social support provision. The formalization of MR sought to bring a necessary level of scientific rigor to the field, defining the condition as originating before the age of 18 and characterized by significantly subaverage intellectual functioning existing concurrently with related limitations in two or more adaptive skill areas, such as communication, self-care, or social skills. Although revolutionary for its time, establishing a clinical term that was also widely adopted by legal and educational systems inadvertently set the stage for its eventual obsolescence due to the powerful sociological forces of stigma and marginalization.

The adoption of **Mental Retardation** was heavily influenced by organizations like the American Association on Mental Retardation (AAMR), which provided the authoritative diagnostic framework used globally. This framework, detailed across successive editions of diagnostic manuals like the DSM (Diagnostic and Statistical Manual of Mental Disorders) and ICD (International Classification of Diseases), cemented MR as the official medical and psychological nomenclature. However, the very nature of defining a deficit in intellectual capacity within a clinical hierarchy meant that the term carried the weight of institutionalization and historical abuse associated with its predecessors. While clinicians used the term neutrally to facilitate research and allocate services, the public perception quickly conflated the clinical definition with societal judgments about capability and worth. This discrepancy between clinical intent and social reception is central to understanding the subsequent negative attitudes that developed towards the terminology, highlighting the difficulty in maintaining a value-neutral descriptor for a complex human characteristic that often requires significant societal support.

Understanding the historical trajectory requires acknowledging the context of segregated institutions and limited rights for individuals with cognitive differences. The clinical utility of **Mental Retardation**, which allowed for the development of specialized educational programs (Special Education) and targeted therapeutic interventions, was constantly undermined by its use in policy that often restricted individual autonomy. For decades, the term served as a gateway to necessary services, yet simultaneously acted as a barrier to full societal inclusion. It became a powerful signifier of difference, often overshadowing the individual's identity, talents, and potential contributions. The growing awareness among self-advocates, families, and professionals regarding the inherent dehumanization embedded in such deficit-focused language catalyzed the intense movement to retire the term entirely, recognizing that language shapes perception, and perception

dictates opportunity and respect.

The Stigmatizing Effects of "Mental Retardation"

The primary driver for the negative attitudes towards the term **Mental Retardation** is its profound and pervasive stigmatizing effect. Over time, the word "retarded" transitioned from a clinical descriptor signifying a developmental delay or limitation into a generalized, highly offensive insult used to denote stupidity, incompetence, or failure across various societal contexts. This linguistic degradation meant that the clinical term itself became irreparably tainted by its colloquial, derogatory usage. For individuals, families, and advocates, the continued use of **MR** in official documents felt like an endorsement of the public's dehumanizing language, making it nearly impossible to separate the neutral diagnostic meaning from the deep social prejudice associated with the slur. This phenomenon created significant emotional distress for individuals receiving services and their families, who felt perpetually marked by a label that fostered misunderstanding and exclusion.

The stigma attached to **Mental Retardation** often resulted in systemic discrimination across various domains, including employment, housing, and social interaction. Employers, educators, and even medical professionals, consciously or unconsciously, often held lower expectations or exhibited discriminatory behavior based solely on the presence of this label. Furthermore, the term contributed to internalizing stigma, where individuals with cognitive disabilities began to associate the label with negative self-worth and reduced aspirations. Advocacy groups vehemently argued that the language was inherently disempowering, focusing entirely on a deficiency rather than emphasizing the person's inherent value or their capacity for learning, growth, and integration. The widespread negative connotations necessitated a strategic linguistic shift to reclaim dignity and foster an environment conducive to inclusion and respect, moving away from language that inherently suggests inferiority.

Sociolinguistic research confirms that labels used within clinical and legal settings possess significant power to shape public attitudes. When a technical term like **Mental Retardation** becomes weaponized in common parlance, its utility as a neutral descriptor is effectively destroyed. The negative attitudes were not merely about preference; they reflected a fundamental moral imperative to stop using language that actively perpetuated harm and marginalization. The continuous fight against the term highlighted the intersection of disability rights and linguistic justice, emphasizing that respectful terminology is a prerequisite for equal treatment. The societal rejection of the term signaled a growing maturity in disability discourse, acknowledging that clinical accuracy should never supersede human dignity, especially when alternative, less loaded terms are available that achieve the same diagnostic precision.

Clinical and Legal Usage of the Term

Despite the widespread public rejection and negative attitudes, the term **Mental Retardation** maintained a tenacious hold within specific bureaucratic, clinical, and legal systems long after advocacy groups began pushing for change. In the United States, for instance, many state and federal statutes, including foundational legislation governing disability services and benefits, codified the term **MR** as the specific legal descriptor required for eligibility. This created a significant logistical hurdle: while clinicians and educators preferred the newer, more respectful terminology, legal professionals often insisted on the statutory term to ensure clients could access essential rights, funding, and protections. The dissonance between evolving clinical best practices and rigid legal definitions meant that service providers were often forced to use a term they found offensive simply to comply with necessary governmental documentation and qualification criteria, thus perpetuating its official use.

In the clinical sphere, particularly prior to the formal adoption of **Intellectual Disability** (ID) in the DSM-5 (2013) and ICD-11, the diagnostic criteria for **Mental Retardation** were highly specific and utilized universally by psychologists and psychiatrists to ensure consistency in research and treatment planning. These detailed criteria focused on three domains: intellectual functioning (IQ below 70-75), adaptive behavior (limitations in conceptual, social, and practical skills), and onset during the developmental period. Clinicians often argued that the term, when stripped of its social baggage, was precise and measurable, essential for differential diagnosis, particularly from other developmental or psychiatric conditions. However, this defense of clinical precision often overlooked the daily lived experience of the individuals being labeled. The increasing recognition that diagnostic accuracy could be maintained using less pathologizing language ultimately undermined the argument for retaining the traditional term, paving the way for the institutional acceptance of ID.

Furthermore, the legal implications of the terminology were profound, particularly in areas concerning criminal justice and capital punishment. The U.S. Supreme Court case *Atkins v. Virginia* (2002) barred the execution of individuals with **Mental Retardation**, necessitating a clear, standardized definition of the condition for legal assessment. While the ruling was protective, it reinforced the official status of the term within the judiciary. This legal reliance created a complex transition period where state laws had to be systematically updated, a slow and cumbersome process. The necessity of legislative action to replace every instance of **MR** with **ID** across thousands of pages of legal code demonstrated the deep entanglement of the outdated terminology within the institutional fabric of society, requiring years of concerted effort by disability rights lawyers and policymakers to fully eradicate.

Advocacy and the Push for Change

The shift away from the term **Mental Retardation** was not a spontaneous linguistic evolution but the direct result of decades of intense advocacy spearheaded by individuals with disabilities, their families, and dedicated professional organizations. Central to this movement was the principle of **person-first language**, which mandates placing the individual before the disability descriptor (e.g., "a person with intellectual disability" rather than "an intellectual disabled person"). This linguistic framework was a powerful tool designed to combat the pervasive tendency of society to define individuals solely by their cognitive limitations. Advocates argued that changing the term was crucial, but changing the grammar of discourse was equally important to ensure that human identity remained primary. This philosophical shift underpinned the entire movement for linguistic reform.

Key organizations played instrumental roles in formalizing the replacement terminology. The American Association on Mental Retardation (AAMR), which had historically defined the term, officially changed its name to the American Association on Intellectual and Developmental Disabilities (AAIDD) in 2007. This institutional change provided immense momentum, signaling that the primary professional body governing the field recognized the moral and practical necessity of the update. Furthermore, the Special Olympics launched the "Spread the Word to End the Word" campaign, mobilizing youth and public figures to pledge to stop using the derogatory slur "retard," thereby directly addressing the social stigma that had contaminated the clinical term. These coordinated efforts transformed the issue from a niche academic debate into a widespread social justice movement demanding linguistic respect.

Advocacy efforts culminated in significant legislative victories, perhaps most notably the passage of Rosa's Law in the United States in 2010. This federal law mandated the removal of the terms **Mental Retardation** and "mentally retarded" from all federal health, education, and labor statutes, replacing them with **Intellectual Disability** and "individual with an intellectual disability." Rosa's Law provided the necessary legal mandate to harmonize federal language with contemporary clinical practice and advocacy standards. This legislative action was pivotal because it provided the authority required to initiate the massive administrative and statutory overhaul needed to cleanse official documentation, ensuring that the federal government officially recognized and endorsed the respectful, person-first terminology sought by the disability community.

The Formal Adoption of "Intellectual Disability"

The formal adoption of **Intellectual Disability** (ID) represents the most significant culmination of the negative attitudes toward **Mental Retardation**. This new term was chosen strategically because it is considered less pathologizing and aligns more closely with international terminology, promoting global consistency in diagnosis and research. The primary motivation for the change

was to select a term that had not yet been co-opted or degraded into a common societal slur. The American Psychiatric Association officially incorporated **Intellectual Disability** into the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in 2013, replacing the previous diagnostic category of **Mental Retardation**. This change was not merely cosmetic; while the core diagnostic criteria--deficits in intellectual functions, adaptive functioning, and onset during the developmental period--remained largely consistent, the new term signaled a profound shift in clinical philosophy toward respect and inclusion.

The transition to **Intellectual Disability** emphasized that the condition pertains to limitations in cognitive functions and adaptive skills, framing the issue as a difference in intellectual processing rather than a global, inherent defect of the person. ID is generally viewed as a less value-laden term, making it easier for individuals and families to accept the diagnosis and seek necessary supports without the immediate emotional burden associated with the historical weight of **MR**. Furthermore, the formal definition used by the AAIDD and codified in the DSM-5 explicitly incorporates the need to consider the context of the individual's community environment, recognizing that disability is not solely an individual trait but also a function of the interaction between the person and the supports available to them. This contextual consideration represents a departure from the purely deficit-based model inherent in the older terminology.

The integration of **Intellectual Disability** into official diagnostic manuals and federal law solidified its status as the preferred and authoritative terminology. While the clinical parameters used to define the condition--mild, moderate, severe, and profound levels of severity--largely remained consistent with the previous classifications of **Mental Retardation**, the new linguistic packaging facilitated better communication among professionals, reduced internal stigma, and streamlined international cooperation. The success of this transition highlights the power of professional bodies and legislative action working in concert to address negative attitudes and institutionalized prejudice, demonstrating a commitment to ethical language that prioritizes the dignity and rights of the individuals being served.

International Perspectives and Nomenclature Shifts

The negative attitudes towards **Mental Retardation** were not unique to the United States; similar linguistic shifts occurred globally, often preceding or coinciding with the changes in North America. Many international bodies and national health systems recognized the pejorative nature of the term and adopted alternatives much earlier. For example, countries often preferred terms translating to "Learning Disability" (though this term carries a different meaning in the U.S.) or, most commonly, variations of **Intellectual Disability**. This international consensus provided significant impetus for U.S. organizations to align their terminology, fostering greater harmonization in research and cross-cultural communication regarding cognitive disabilities. The World Health Organization (WHO), in its International Classification of Diseases (ICD), phased out the use of **Mental**

Retardation in favor of **Intellectual Developmental Disorders** (IDD) in the ICD-11, further cementing the global trend away from the outdated label.

The shift towards **Intellectual Disability** reflects a broader, global movement within disability studies that emphasizes rights and inclusion over clinical pathology. The United Nations Convention on the Rights of Persons with Disabilities (CRPD), adopted in 2006, strongly promotes person-first and rights-based language, influencing member states to review and update their national terminology to eliminate discriminatory terms. This international pressure reinforced the advocacy efforts within individual nations, making it clear that the continued use of **MR** was incompatible with modern human rights standards. The consistent adoption of terms like **Intellectual Disability** across diverse linguistic and cultural contexts indicates a shared understanding that certain words inevitably accumulate stigma and must be retired to protect vulnerable populations.

However, the global transition has faced challenges related to linguistic variation and bureaucratic inertia. While the intent to use less stigmatizing language is universal, the exact translation and interpretation of terms like **Intellectual Disability** can vary, sometimes leading to confusion regarding eligibility for services in multinational settings. For instance, in some Commonwealth nations, "learning disability" refers to what the U.S. calls Intellectual Disability, while "learning difficulty" refers to specific academic challenges (like dyslexia). Despite these minor variances, the overarching global attitude is firmly against the use of **Mental Retardation**, reflecting a collective rejection of deficit-focused labels and a commitment to standardized, respectful, and rights-affirming terminology in health, education, and legal systems worldwide.

Challenges of the Euphemism Treadmill

While the adoption of **Intellectual Disability** was necessary and widely praised, professionals and advocates remain acutely aware of the phenomenon known as the **euphemism treadmill**. This concept describes the cyclical process where a new, less offensive term introduced to replace a stigmatized one eventually acquires the same negative connotations over time, necessitating yet another replacement. The historical trajectory from "idiot" to "feeble-minded" to **Mental Retardation** clearly illustrates this cycle. The concern is that if societal attitudes toward people with cognitive differences do not fundamentally change, the term **Intellectual Disability**, despite its current clinical neutrality, will eventually be co-opted into common derogatory slang, rendering it as stigmatizing as its predecessor.

The efficacy of the transition, therefore, rests not just on changing the word itself, but on changing the underlying social prejudice. Advocates stress that linguistic change must be accompanied by robust educational programs, increased societal integration, and policy changes that ensure true equality and opportunity. If individuals with **Intellectual Disability** continue to face systemic

barriers, exclusion, and low expectations, the term used to describe them will inevitably become associated with those negative outcomes. The challenge lies in sustaining the momentum of respect and inclusion so that the new terminology remains a neutral descriptor rather than a marker of marginalization. This requires ongoing vigilance from professional organizations, media, and the public to ensure responsible and respectful language use.

Furthermore, the **euphemism treadmill** poses practical challenges for historical accuracy and research. When terminology changes frequently, longitudinal research becomes complex, requiring careful mapping between older diagnostic categories (like the various levels of **Mental Retardation**) and newer ones (like degrees of **Intellectual Disability**). While the transition was essential for ethical reasons, researchers must constantly contextualize their findings to ensure that data collected under the MR label remains comparable and relevant to current studies using the ID label. The commitment to ethical language must be balanced with the need for clinical and historical continuity, requiring careful documentation and standardization efforts to ensure that progress in understanding and treating the condition is not lost during linguistic shifts.

Future Directions in Person-First Language

The future direction of language regarding cognitive differences focuses heavily on reinforcing **person-first language** and moving toward language that emphasizes capabilities and necessary supports rather than inherent deficits. There is a growing movement, particularly within self-advocacy communities, to adopt identity-first language (e.g., "Autistic person") in certain contexts, but for intellectual disability, the consensus remains strongly in favor of person-first language ("person with an intellectual disability"). The overarching goal is to ensure that terminology is functional for clinical and legal purposes while simultaneously minimizing dehumanization and maximizing social dignity. This involves continuous monitoring of public discourse and proactive educational interventions to correct the misuse of technical terms.

One critical area for future focus is the role of the media and entertainment industry in shaping public attitudes. Negative stereotypes are often perpetuated through casual or comedic use of ableist language. Future advocacy efforts must target these cultural institutions to promote accurate, respectful, and nuanced portrayals of individuals with **Intellectual Disability**. By increasing visibility and accurate representation, the public attitude shift can be sustained, potentially slowing or halting the **euphemism treadmill**. The goal is to reach a point where the diagnostic label itself is so detached from negative social judgment that it can function purely as a tool for accessing necessary resources.

Ultimately, the negative attitudes towards the term **Mental Retardation** served as a powerful catalyst for positive change, forcing society and professional bodies to confront the profound impact of language on human rights. The ongoing commitment to using respectful terminology like

Intellectual Disability is a reflection of a maturing disability rights movement that understands that full inclusion requires both policy changes and linguistic integrity. Future efforts will continue to refine language, focusing on individual supports and capabilities, ensuring that the terminology used in clinical and legal settings always reflects the fundamental dignity and value of every person.

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