

A Sociological Perspective on Labeling in Mental Retardation*

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Abstract: The recent literature on labeling in mental retardation is reviewed and a conceptual scheme based on Scheff's model is presented for future study of the labeling problem. The issue of the medicalization or demedicalization of mental retardation is discussed in light of P.L. 94-142.

Since the 1960s, legislators, administrators, educators, clinicians, parents, and others, have shown much concern for the harmful effects of labeling a mentally retarded individual. An intensive review of the literature on this problem leads to much confusion.

For the clinician, labeling is part of the diagnostic procedure. Diagnosis is often dependent on the proposed or actual disposition of the case and becomes more accurate when treatment procedures are available and tested. As treatment procedures are proven, more diagnoses seem to be made allowing the procedures to be used. Diagnostic reliability is strongly related to the severity of disorder with diagnostic reliability increasing as symptomatology is more evident and specified: the diagnosis of severely and profoundly mentally retarded individuals is very accurate; in moderate mental retardation diagnoses the reliability begins to decline; and, for mild mental retardation diagnostic reliability is very low. Mercer (1973) has presented evidence suggesting that mild retardation labels are inappropriately applied to many minority low income children. In these instances diagnostic reliability appears directly related to socioeconomic status.

A clinical diagnosis differs from a research diagnosis. The latter is the collection of information on a sample of people with classification playing a part. Researchers often define a disorder being studied and diagnose the sample respondents on the basis of an objective series of criteria (Rowitz 1974a). Actually, researchers in mental retardation use clinical diagnosis in studies of treated prevalence or service use. Research diagnosis is used in many community surveys. Labeling occurs in both instances; however, its meaning differs in each of the previous examples.

Much discussion of mental retardation labeling relates to the attachment of a deviant tag or status to an individual whose behavior does not appear

normal to the identifier of the problem (Rowitz 1974b). Labeling does not occur in a social vacuum and it is a process which needs to be viewed in the larger perspective of a community social system. Individuals designated mentally retarded are often termed deviant as are mentally ill persons or drug addicts who as well do not fit into the mainstream of society. Glaser (1971) referred to deviance as an individual's attributes or actions regarded as objectionable in a particular social setting. There are many types of behavior following this pattern but not labeled deviant—many eccentricities are tolerated. Either the degree of or the extreme nature of an action seems to warrant the label deviant. Erikson (1962) says deviance is not a property inherent in the action or attributes of a given individual. As the label *deviance* is conferred upon the acts or attributes of an individual by the audiences viewing the acts, deviance becomes a sociological problem in origin (Becker, 1963). If the label deviant is successfully applied, these individuals become deviant because of the attachment of the label. The sociological assumption is that the individual will usually also accept the label deviant.

MacMillan (1977) has correctly argued that the traditional sociological perspective on labeling is oversimplified. A number of factors may influence the labeling of an individual as mentally retarded and affect the impact of the label on the individual:

- (a) The individual's pre-labeling experiences such as family experience, peer group experience, and school experience;
- (b) The effects of more than one stigmatic label on the individual—e.g. mentally retarded and juvenile delinquent;
- (c) The effects of informal labeling by friends and neighbors;
- (d) The psychological impact on the individual of the formal identification of mental retardation by the school;
- (e) The reaction of the child's family to the mental retardation label;
- (f) The actual label used in contrast to the several possible names for the same set of problems, (p. 266-270)

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A Model Conceptual Framework

Several hypotheses should provide direction to the conceptual development of a theory of labeling in the mental retardation field and put a better perspective on the many aspects previously discussed. The labeling model is an alternative to the medical model. Scheff (1966, 1975) argues that the medical model, specifically procedures in the diagnosis of mental illness, is oriented towards the inner state of the individual. The labeling model is oriented to external events. A concentration on the external reactions to behavior does not negate the reality of real internal stress or biomedical difficulties of an individual. A labeling approach does not conflict with an argument that a medicalization of social problems is occurring. This type of theory possibly explains the consequences of medicalization of problems such as mental retardation and child abuse.

In *Being Mentally Ill: A Sociological Theory* (1966), Scheff presents a nine-item labeling theory of deviance for mental illness, applied here as seven hypotheses which may lead toward a theory of labeling for mentally retarded persons (Table 1).

(1) **Residual rule breaking arises from fundamentally diverse sources.** As we review the reasons for rule breaking we find a number of possible explanations—organic malfunctions or defects, psychological problems, external volitional acts of innovation or defiance, social incompetence.

(2) **Most residual rule breaking is denied and is of transitory significance.** This hypothesis is most relevant to the mildly mentally retarded individual. Despite public labeling in schools, many of these children do not carry the mental retardation label into their home community from the school environment (Mercer, 1973). Moreover, when the education experience is over, the individual may lose the label completely (Hobbs, 1975, a, b), although for more severe forms of disability denial of the label is more difficult; for the profoundly mentally retarded person, the reality of labeling may never be understood.

(3) **Stereotyped imagery of mental retardation is learned in early childhood.** Young children learn early the words *stupid* and *dummy*. In fact, these words are often seen by children as the way to really attack another youngster. A father,

TABLE 1

A COMPARISON OF SCHEFF'S LABELING THEORY OF MENTAL ILLNESS TO MENTAL RETARDATION

Scheff's Labeling Theory for Mental Illness	Labeling Theory for Mental Retardation
1. Residual rule breaking arises from fundamentally diverse sources (that is, organic, psychological, situations of stress, volitional acts of innovation or defiance).	1. Residual rule breaking arises from fundamentally diverse sources (that is, organic, psychological, situations of stress, volitional acts of innovation or defiance and social incompetence).
2. Relative to the rate of treated mental illness, the rate of unrecorded residual rule breaking is extremely high.	Not relevant to mental retardation
3. Most residual rule breaking is "denied" and is of transitory significance.	2. Most residual rule breaking is "denied" and is of transitory significance.
4. Stereotyped imagery of mental disorders is learned in early childhood.	3. Stereotyped imagery of mental retardation is learned in early childhood.
5. The stereotypes of insanity are continually reaffirmed, inadvertently, in ordinary social interaction.	4. The stereotypes of mental retardation are continually reaffirmed, inadvertently, in ordinary social interaction.
6. Labeled deviants may be rewarded for playing the stereotyped deviant role.	5. Labeled mentally retarded individuals may be rewarded for playing the stereotyped deviant role.
7. Labeled deviants are punished when they attempt to return to conventional roles.	6. Labeled mentally retarded individuals are punished when they attempt to return to conventional roles.
8. In the crisis occurring when a residual rule breaker is publicly labeled, the deviant is highly suggestible and may accept the label.	7. When a rule breaker is publicly labeled mentally retarded, the individual is highly suggestible and may accept the proffered role of the mentally retarded person as the only alternative.
9. Among residual rule breakers, labeling is the single most important cause of careers of residual deviance.	Too simplistic a hypothesis for mental retardation.

for example, may unthinkingly criticize himself verbally by calling himself *dumb*.

(4) **The stereotypes of mental retardation are continually reaffirmed inadvertently, in ordinary social interaction.** Television and the other mass media help in the socialization of stereotypes regarding the deviant and in fact those with all kinds of handicaps. A viewing of several current cartoon shows presents many such stereotypes.

(5) **Labeled mentally retarded individuals may be rewarded for playing the stereotyped deviant role.** Demands on these individuals may lessen. Teachers may be kinder because the mentally retarded individual is not self-sufficient and with this label the individual becomes entitled to special services which are unavailable to the unlabeled individual. Many professionals owe their jobs, many school districts their special education funding, to the labeling of children (Gallagher, 1976; MacMillan, 1977).

(6) **Labeled mentally retarded individuals are punished when they attempt to return to conventional roles.** The issues of deinstitutionalization and normalization become important here. Edgerton (1967) shows that life is not easy for many of the mentally retarded individuals leaving the state institution for the community.

(7) **When a rule breaker is publicly labeled mentally retarded, the individual is highly suggestible and may accept the proffered role of the mentally retarded person as the only alternative.** The child is easily influenced, and may not understand all the ramifications of a mental retardation label. If organic deficits exist, the child may know something is wrong and yet not understand the labeling process and its results. We know that minority children often ignore the label and act in most parts of their lives as if the label had never been given (Mercer, 1973). The questions regarding handicapped children and their reactions to the labels given to them need further study.

Two Scheff hypotheses (1966) were not applicable to mental retardation. For the mentally ill, Scheff has hypothesized that the rate of unrecorded residual rule breaking is extremely high. With regard to the rate of recorded mental retardation, we are often dealing with an inflated figure rather than a deflated figure that is the case with rates of reported mental disorder (Mercer, 1973). However, this is not as clearcut as it first appears. It is important to distinguish between unrecorded cognitive and social incompetency on the one hand and unrecorded residual rule breaking on the other. There are probably more instances of unrecorded

cognitive and social incompetency which are unlabeled than are labeled in education, whereas the rate of recorded residual rule breaking is inflated. Some clarification exists in the work of Farber (1968). Farber argues there is a distinction between deviance and competency. A deviant is an individual who voluntarily commits an act or engages in behavior which may lead to official labeling as a deviant. Other individuals may involuntarily commit acts or engage in behavior which may lead to official labeling because of an inability to engage in socially acceptable behavior. Farber further argues that mentally retarded individuals fall into this latter group. This distinction may be too simplistic. Issues of competency may involve organic deficits on the one hand or social dysfunction by middle class standards on the other. Moderately, severely, and profoundly mentally retarded individuals more clearly engage in socially disapproved behavior involuntarily. An important issue relates to whether individuals who are labeled mildly mentally retarded commit socially disapproved acts voluntarily or involuntarily.

Scheff also hypothesizes that labeling is the single most important cause of deviant careers. This is much too simplistic with regard to the labeled mental retardation population. For the profoundly mentally retarded individual, labeling from a psychological perspective may not mean very much. For the individuals who are labeled mildly mentally retarded, labeling may or may not affect them socially or psychologically (Krasner, 1977; Mercer, 1973). This reaction is often dependent on such factors as socio-economic status, race, and ethnic background. If the mental retardation label given by a school does not carry over into community relationships, it becomes difficult to talk about a deviant career (Rowitz, 1974b).

Societal Reaction Argument

The concept of societal reaction or social control underlies all seven hypotheses. A shift has occurred from a consideration of the etiology of mental retardation to a concern with how mentally retarded individuals are controlled. In the Hobbs report (1975b), Rains and committee colleagues argue that the development of the category of *exceptional children* is historically grounded in a perspective of help and service rather than punishment. The children who are considered exceptional are those who create social problems for institutions responsible for their welfare. Rains talks about the politicalization of deviance. When agencies are studied that treat special populations, it is found that the organi-

zation of these agencies and the determination of appropriate cases for the agency are often made quite independently of the acts, characteristics, or qualities of persons coming to these agencies for service. In fact, the ideal type of agency case is often quite biased demographically and dependent on such variables as: the professional's conception of those who are sick and need help; the specific demographic characteristics of potential service users that any agency considers to be its clientele; and, the pattern of interagency referrals that produces new clients (Rowitz, 1974a). Moreover, the administrators and personnel of mental retardation service agencies tend to want to select as clients those people who will most probably be labeled as a success in a treatment program. In a study of a state operated clinic (Rowitz, 1973), it is seen that demographic changes in the characteristics of clinic users vary over time. Changes in such things as administrative decisions about geographic areas from which cases may come cause these variances. The development and expansion of many alternative types of community services can also affect the demography of service use and thus the labeling of individuals by various types of agencies (Rowitz, O'Conner & Boroskin, 1975).

Medicalization of Social Problems

The issue of the medicalization of social problems frequently appears in the sociological literature and also has political ramifications. The term *medicalization* refers to defining behavior as a medical problem or illness and mandating that the medical profession provide some kind of treatment (Conrad, 1975). The mental retardation label can exist whether the identifiers of the problem are members of the medical profession or some other helping profession. Implied in the concept of medicalization is the notion that sociologically or psychologically based problems can be defined as medical problems. Learning disabilities, child abuse, alcoholism, and drug addiction are all undergoing medicalization.

Fox (1977) notes an increase in the number and types of behavior that have come to be defined as illnesses, arguing that historically, many problems that are now seen as medical were earlier considered to be sinful. Religious leaders determined the results of sin and the punishment for these sins. With the secularization of society, many of these sins have become crimes and are handled by the criminal justice system. Now we are moving into a period where aberrant behavior of many kinds is seen as an illness to be treated by medical prac-

tioners. Fox (1977) connects the increase in medicalization to such factors as the so-called medical mystique of physicians, the biotechnological capacities of modern medicine, and the increasing costs of medical and health care which expand the influence of the medical profession in this country.

When the mental retardation field is viewed, the medicalization waters become muddied. At times it appears that mental retardation should be viewed as a medical problem to be dealt with by medical expertise. On the other hand, we can also see the continuing *educalization* of mental retardation. Public Law 94-142 (U.S., 1975) appears to demedicalize mental retardation problems by making schools responsible for the education and treatment of all handicapped children. Despite the increasing role of school personnel in the diagnosis of mental retardation, the law protects children by requiring the right to due process, protection against discriminatory testing in diagnosis, placement in the least restrictive educational environment, and the preparation of individualized program plans for each child.

It may be possible that a medical and educational interface might occur relative to the labeling of mentally retarded children. The whole issue of social and political control is critical here and is yet to be resolved. The medical profession feels that diagnosis of mental retardation is a medical issue first, yet the educational professions feel that mental retardation is an educational issue. It seems clear that the question of professional turf is still unresolved (MacMillan, 1977; Richmond, Tarjan, & Mendelsohn, 1974).

Summary

Labeling is not a static event. It has a pre-history as well as a post-history for the individual. It must be seen as part of the whole continuum of care cycle for both the mentally retarded individual and the family. The identification of mental retardation has positive as well as negative consequences. A new way to look at labeling is presented in the application of the Scheff (1966) labeling model to the mental retardation field. The issue of social control was discussed and elaborated upon relative to the official identifiers of mental retardation. It was hypothesized that PL 94-142 (U.S., 1975) would give educational personnel more control in the delivery of service to handicapped children.

It is important to differentiate levels of competencies from official labels. A label is only useful if it provides information that can be used to provide services to the individual. New methods of

educational labeling might not be beneficial unless the labels lead to changes in the delivery of educational services to handicapped children.

The labeling controversy is still unresolved. Some ideas for future research can be expected to grow out of an evaluation of our past endeavors. Future research should also be concerned with the effects of self-labeling, the epidemiological aspects of labeling, and the testing of the Scheff hypotheses in the investigations of labeling in mental retardation.

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