

TWENTIETH-CENTURY DEFINITIONS OF MENTAL RETARDATION

As formal definitions of mental retardation were developed during the first half of the 20th century, they tended to reflect the judgment of chronicity. The most important of these, and the one that continues to influence the defining of mental retardation, was authored by the psychologist Edgar Doll (1941). His pioneering definition included six elements that he considered essential to the concept of mental retardation:

(1) Social incompetence, (2) due to mental subnormality, (3) which has been developmentally arrested, (4) which obtains at maturity, (5) is of constitutional origin, and (6) is essentially incurable, (p. 215)

The first four of these elements have continued to be overtly central to the prevailing conceptualization of mental retardation. Social incompetence associated with deficits in mental ability is a thread that runs from Doll's definition through subsequent definitions to the most current. The same is true for his emphasis on mental retardation as a disability that originates during the developmental period.

The last two elements of Doll's definition, however, are not found as formal elements of contemporary definitions of mental retardation. Retardation is no longer

viewed as always resulting from "constitutional" factors. It has long been recognized that environmental variables also are important as causes of mental retardation. Much retardation, for example, is associated with the depriving effects of poverty. This recognition, however, is not operative in many community and school contexts where "true" retardation is still considered to be physiological in origin. Mental retardation is also no longer considered to be an "incurable" condition in official definitions. The goal of educational services for many students, in fact, is to help those students achieve a level of competence at which it would no longer be appropriate to describe them as having mental retardation. The attitude of incurability about children and adults with mental retardation has continued to be a reality, however, in the minds of many people.

The legacy of Doll's conceptualization of mental retardation can be seen most clearly in definitions that have been developed during the second half of the 20th century by the American Association on Mental Retardation (AAMR). The definitions published by this professional organization have always included the criteria of low measured intelligence and deficits in social competence. They have also consistently described mental retardation as a developmental disability.

In 1959 the AAMR, at that time called the American Association on Mental Deficiency, published a definition of mental retardation that read as follows:

Mental retardation refers to subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior. (Heber, 1959)

The definition was revised in 1961. That revision specified the meaning of the term *subaverage general intellectual functioning* in a manner that was to have considerable impact on the field of mental retardation. One standard deviation below the mean on an intelligence test was delineated as the point at which intellectual functioning should be considered *subnormal* (Heber, 1961). This specification meant that on an IQ test with a mean of 100 and a standard deviation of 15, any score below 85 would be diagnostic of mental retardation. If the total population was tested and classified on this basis, almost 16% would be diagnosed as having mental retardation. Even higher percentages would be expected to be found in subpopulations where minority status, language factors, or socioeconomic background depresses intelligence test scores.

There were criticisms of the concept of adaptive behavior as it appeared in the 1961 definition. The argument was made that adaptive behavior as it was presented in the definition was not actually functional for the diagnosis of mental retardation. In reality, it was argued, the determination of retardation continued to be based on intelligence tests and the idea that intelligence was not significantly "associated" with adaptive behavior in this process (Clausen, 1972).

In 1973 an AAMR committee again revised the definition. The committee constructed this revision with criticism of the 1961 definition in mind. It specified that *sig-*

nificantly subaverage general intellectual functioning was to be determined by a score of at least *two standard deviations* below the mean on an intelligence test (Grossman, 1973). This meant that the cutoff point for mental retardation was essentially moved downward from 85 to 70. This change lowered the percentage of the population that might be identified as having mental retardation from 16% to approximately 2.25%. This revision meant that fewer people would be labeled retarded because of language differences, socioeconomic factors, or minority status. It also meant, however, that fewer students were eligible for special education services. This is a particularly important consideration since the 1973 AAMR definition was adopted for defining mental retardation under the Education for All Handicapped Children Act of 1975 (P.L. 94-142). This definition also placed more emphasis on the importance of adaptive behavior and extended the developmental period upward from 16 to 18 years of age.

In 1977 the AAMR published another manual on mental retardation terminology and classification (Grossman, 1977). Although there were no substantive changes to the definition in this manual, the role of clinical judgment was given greater emphasis. Allowance was made as well for diagnosing people with IQs up to 10 points above the 70 cutoff as having mental retardation if they also showed marked deficits in adaptive behavior. A 1983 AAMR definition further expanded the developmental period from conception (instead of birth) to age 18 (Grossman, 1983). This change officially made persons with mental retardation resulting from prenatal factors eligible to be classified.

The 1992 Revision of the AAMR Definition

The AAMR published the most recent revision of its manual on the definition and classification of mental retardation in 1992. The definition itself includes dramatic changes. It reads as follows:

Mental retardation refers to substantial limitations in present functioning. It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests before age 18. (Lukasson et al, 1992, p. 1)

This conception of mental retardation is presented by AAMR as a paradigm shift. Retardation is no longer to be viewed as being characteristic of an individual. It is the product of interactions between a person, and the nature and demands of that person's environment. The phrase "limitations in present functioning" is used to indicate that mental retardation is a current state, rather than a permanent trait. This change is meant to emphasize that mental retardation may be a transitory condition.

There are other distinctly different elements in the AAMR's new perspective on mental retardation. The global term adaptive behavior has been extended to 10 specific adaptive skill areas, each of which is discussed at some length in the manual. The

four levels of severity of mental retardation are replaced by a system that classifies the intensities and patterns of support required by individuals: *intermittant needs*, which are episodic in nature and do not always require support; *limited needs*, which are consistent over time but limited in intensity; *extensive needs*, which are long term and serious; and *pervasive needs*, which are constant and intense throughout life (Lukasson et al., 1992).

Four assumptions are presented as being essential to the application of the definition:

1. Valid assessment considers cultural and linguistic diversity as well as differences in communication and behavioral factors.
2. The existence of limitations in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the person's individualized needs for support.
3. Specific adaptive limitations often coexist with strengths in other adaptive skills or other personal capabilities.
4. With appropriate supports over a sustained period, the life functioning of the person with mental retardation will generally improve.

The 1992 AAMR revision also emphasizes leeway in the use of IQ scores in diagnosing mental retardation. It calls for a score of "approximately 70 to 75 or below" (Lukasson et al., 1992, p. 5).

MENTAL RETARDATION, THE AAMR CONSTRUCT, AND THE CRITICS

A great deal of professional and academic controversy has been generated by the 1992 revision of the AAMR definition and its changes in the classification guidelines on mental retardation. Even within the AAMR there have been sharp differences of opinion concerning the revised definition. John Jacobson, former president of the AAMR Psychology Division, was quoted as saying, "The new AAMR manual is a political manifesto, not a clinical document" (Michaelson, 1993, p. 34). He described the changes in diagnosing mental retardation as being politically motivated rather than research based. This position, and other criticisms of the revisions, have appeared elsewhere in professional literature (Jacobson & Mulick, 1993; MacMillan, Gresham, & Siperstein, 1993; MacMillan, Gresham, & Siperstein, 1995).

Greenspan (1995) observed that the AAMR revision represents a "less defectology-oriented approach to conceptualizing disorder, a view that is reflective of both new treatment approaches as well as new social trends" (pp. 684-685). On the other hand, he pointed out that the new definition was not grounded on a research base of any kind. He argued that this is a vulnerability that makes the definition subject to

major criticisms. According to Greenspan, "relatively full acceptance of any radical new classificatory scheme (no matter how much philosophical or practical merit it might have) is likely to occur only if the promoters of the scheme are able to advance the illusion, if not the reality, that the field it serves is driven by scientific methods and findings" (p. 685).

SHIFTING PARADIGMS

The authors of the most recent AAMR manual (Lukasson et al., 1992) have characterized their revisions as a paradigm shift in the field of mental retardation. This paradigm shift is presented as consisting of two facets. The first of these is a change in the conception of mental retardation from a trait existing in an individual to an expression of the interaction between a person with limited intellectual and adaptive skills, and that individual's environment. The second element of the paradigm shift is the emphasis on the pattern of the person's needs rather than a focus on that person's deficits (Schalock et al., 1994).

Paradigm shifts may be critical to advancement and improvement in any field of endeavor. Thomas Kuhn (1962), in his classic book *The Structure of Scientific Revolutions*, defined paradigms as the shared world views of scientists, as shared ways of viewing certain realities. Kuhn argued that these shared views eventually become so strong and institutionalized that only a sudden and dramatic break from these conventional perspectives can bring on a positive revolution in thinking.

It must be recognized, however, that unlike physics, where a paradigm shift from the world view of Newton to that of Einstein did nothing to change the reality of the physical universe, a paradigm shift in the field of mental retardation is likely to have profound implications for the education, care, and treatment of millions of human beings.

What is the purpose of defining mental retardation? If it is to create greater understanding of the people whose lives are touched by retardation, Robert Edgerton's (1993) words from the newest edition of *The Cloak of Competence* are important to consider:

There are many cognitively limited people in the United States and the rest of the world who live in dramatically different social cultural worlds. Until we enter those worlds and learn from the people who live in them, we will not know what mental retardation is or what people with it can accomplish, and that what they can accomplish can enlighten and enlarge us all. (p. 234)

The effort to define mental retardation in a way that is as scientifically accurate as possible continues. The effort to define it in a way that promotes greater sensitivity to the needs of people with mental retardation also continues. The successful resolution of the tension between meeting these two goals will determine the future of a social construct that promotes care rather than control for the people whose lives are central to this construction.

HISTORICAL GLIMPSES OF THE IMPERSONALIZATION OF RETARDATION

The eminent American psychologist Seymour Sarason (1985) observed, "Mental retardation is never a thing or characteristic of an individual, but rather a social invention stemming from time-bound societal values and ideology that makes diagnosis and management seem both necessary and socially desirable" (p. 233).

The fact that social values are "time-bound" is powerfully illustrated by a statement from Oliver Wendell Holmes. In his book *The Common Law*, published in 1881, Holmes wrote, "The life of the law has not been logic; it has been experience. The felt necessities of the time . . . [are the sources of law]" (p. 1). When Holmes spoke for the majority of the Supreme Court in 1927 supporting the right of the Commonwealth of Virginia to sterilize people who had been diagnosed as "feebleminded," he was upholding a "felt necessity" of his time and culture. He was also acting in accordance with a "felt necessity" that has a long history in American society. The life of Laura Bridgman provides a striking example of this history.

Laura Bridgman and Mental Retardation

Laura Bridgman was born into a prominent Massachusetts family in 1829. At the age of 2 she was rendered deaf and blind by scarlet fever. In 1837 she came to live at Perkins Institute for the Blind in Boston. There, she was tutored by the founder, Dr. Samuel Gridley Howe. Howe devised a teaching method that built on her ability to feel the differences in shapes of objects. Through drill and practice in distinguishing shapes, he led her to understand that these objects could be given names. At first he used labels with raised print on them to assign names that Laura could comprehend. He then taught her to form words using movable letters. He was thus teaching her by methods similar to those that were used for other students at Perkins who were blind. Eventually, however, he shifted to a communication method that had been developed for students who were deaf. He began teaching her words using finger spelling. He spelled words into her hand, and then associated them with objects and actions. This was the method, of course, that later came to be associated with Anne Sullivan's teaching of Helen Keller.

Laura's fame was eventually eclipsed by the extraordinary accomplishments of Helen and Anne. It is ironic that little note has been taken of the fact that Anne Sullivan, herself a student at Perkins, learned to communicate this way with Laura Bridgman, and then applied what she had learned to her teaching of Helen Keller (Smith, 1987).

For several decades during the 19th century, however, Laura Bridgman attracted international attention and Samuel Gridley Howe's work with her was heralded with as much admiration as the "Miracle Worker" would later receive. To many American intellectuals she became a symbol, "exemplifying the power of enlightened educational

techniques and their capacity to transform seemingly hopeless cases" (Gallaher, 1995, p. 282).

As Howe began to communicate with Laura about abstract ideas, he found that her mind was not a blank slate. He described her internal life as a soul jailed in a body that was "active, and struggling continually not only to put itself in communication with things without, but to manifest what is going on within itself (S. Howe, 1893, p. 9). Howe described Laura's internal life, as he discovered it in its natural and untouched state, as being of the highest moral character. He found that "her moral sense, is remarkably acute; few children are so affectionate or so scrupulously conscientious, few are so sensible of their own rights or regardful of the rights of others" (S. Howe, 1893, p. 50).

To support his argument that Laura was innately moral, he described her behavior toward other people after she had been liberated by his teaching and was enabled to communicate. He reported that she was always eager to share with others and to help take care of sick people. He also said that she showed a keen sense of sympathy for people with disabilities. Howe noted, however, one exception to Laura's expressions of natural altruism. He said that she showed an "unamiable" lack of respect for the children at the Perkins Institution whom she considered to be mentally inferior to herself. Interpreting this as an understandable manifestation of her Anglo-Saxon heritage, he excused the advantage she took of these children when she expected them to "wait on her" (S. Howe, 1893, p. 20).

One of the most famous of Laura's powerful and influential visitors at Perkins was Charles Dickens. His admiration for her began with his reading Howe's accounts of his instruction of Laura. It increased when he visited her in Boston. For Dickens, Laura Bridgman was "both charming and inspirational: a merry, graceful, and intelligent young girl, she seemed also to symbolize the possibility of spiritual awakening and redemption" (Gitter, 1991, p. 163). Dickens described his visit to Laura at Perkins in *American Notes*. He relayed his impressions of her and he also quoted from Howe's reports. In his account he repeats Howe's observation that she had disdain for those children whom she believed to be intellectually inferior (Dickens, 1842).

Samuel Gridley Howe is, of course, a person of importance in the history of mental retardation. In addition to his work with students with blindness and deaf-blindness, he was an early advocate for the education of students with these disabilities. He convinced the legislature of Massachusetts to provide funding for a school for the "teaching and training of idiotic children" in October of 1848 (M. Howe & Hall, 1904, p. 229). The school was initially housed at Perkins Institute. According to two of his daughters, however, Dr. Howe soon discovered that his blind students resented deeply the presence of the students with mental retardation under their roof. His daughters interpreted this resentment as an expression of fear that they might come to be associated with the retardation of these "weaker brethren" (p. 231). They quoted Laura Bridgman's journal as evidence of this feeling of resentment. Laura expressed the hope that the students with mental retardation would not actually come to Perkins

and the fear that if they did they would "have our rooms ... [and] our nice sitting room in a few days" (M. Howe & Hall, 1904, p. 231).

Laura's fears regarding the perceived association between herself and her "weaker brethren" may not have been unfounded. Indeed a literature has developed around the very notion of the transferability of social stigma, the process in which a "normal" person is seen by others as possessing the characteristics of a stigma merely by a close association with a stigmatized other (Goffman, 1963).

There is evidence to suggest that mental retardation carries the most debilitating socially constructed stigma. Gibbons (1985) contends that persons with mental retardation themselves are acutely aware of this stigma and tend to react with derogation to their own peers' lack of social competence and physical attractiveness.

Laura Bridgman may have been acutely aware of the very real potential of being perceived as incompetent by association and of the social consequences inherent in that perception. The threat of a devalued identity provides a powerful incentive for maintaining both physical and social distance from people more seriously stigmatized. As Goffman (1963) suggested, "In general, the tendency for a stigma to spread from the stigmatized individual . . . provides a reason why such relations tend either to be avoided or to be terminated, where existing" (p. 30). Perhaps it was this attempt to avoid stigma by association that explains the attitude of Laura Bridgman toward mental retardation. It may also explain the phenomenon of what might be called differential advocacy (Smith & Anton, 1997).

Helen Keller and Mental Retardation

Another example of the differential advocacy that has worked against people described as being mentally retarded is found in Helen Keller's life. It is particularly striking given her role as a great advocate for the rights of people with disabilities.

A fascinating book titled *The Black Stork* (Pernick, 1996) concerns the work of a physician who openly practiced euthanasia on "defective" newborns beginning in 1915. Dr. Harry Haiselden not only allowed infants with severe disabilities to die, he administered drugs to speed the deaths of several of these newborns. He also campaigned for the widespread adoption of these practices, and produced and starred in a movie promoting euthanasia, "The Black Stork." The film was based on Haiselden's eugenic arguments, and was shown in commercial movie theaters from 1916 through the 1920s.

Helen Keller supported Haiselden's eugenic campaign. In the December 18, 1915, issue of *The New Republic*, Helen Keller expressed the following opinions:

It is the possibilities of happiness, intelligence and power that give life its sanctity, and they are absent in the case of a poor, misshapen, paralyzed, unthinking creature. . . . The toleration of such anomalies tends to lessen the sacredness in which normal life is held.

It seems to me that the simplest, wisest thing to do would be to submit cases like that of the malformed idiot baby to a jury of expert physicians.... A mental defective . . . is almost sure to be a potential criminal. The evidence before a jury of physicians considering the case of an idiot would be exact and scientific. Their findings would be free from the prejudice and inaccuracy of untrained observation. They would act only in case of true idiocy, where there could be no hope of mental development, (pp. 173-174)

Helen Keller's development as an intellectual and as an advocate took place within the context of the eugenics movement. It also occurred within the environment of political progressivism. Progressive thought held that most of the problems of society, and those of individuals, could and should be reduced to scientific terms, and resolved by scientific means. Helen's trust of a "jury" of physicians is very consistent with the faith in scientific progress that characterized the cultural climate of her formative years as a social activist. Her opinion that "true idiocy" lessens the sanctity of "normal life" reflects the eugenic principles to which she was certainly exposed.

In addition to being an advocate for people with disabilities, Helen Keller also became a political activist and a spokesperson for victims of poverty, economic exploitation, gender discrimination, and other forms of oppression (Foner, 1967). Helen's voice of advocacy was bold for its time. It was focused, however, on the potential for social intercourse and productivity in the lives of ignored, misunderstood, and exploited people. In that regard she moved beyond a social context that devalued many people with blindness, deafness, and other physical disabilities, for example, and she crusaded for their right to earn a place in society. She did not believe, however, that this right extended to those people who might never "earn" their own way in society.

WHOLENESS AND PERSONHOOD: LEAVING MENTAL RETARDATION BEHIND

In *Coming of Age in Samoa*, Margaret Mead (1928) included a discussion of people with disabilities in the Samoan culture she described in that book. She not only provided profiles of those Samoans with disabilities but, perhaps more importantly, she described a Samoan society that possessed "more charity towards weakness than towards misdirected strength" (p. 182).

Mead returned to this theme many years later. In 1959 she spoke to a conference sponsored by the American Association on Mental Deficiency (AAMD). In her remarks she referred to a statement made by a group of Catholic nuns who worked with children with mental retardation. She quoted them as saying that they were attempting to make it possible for the children whom they cared for to make a "contribution in time as well as in eternity" (Mead, 1959, p. 253).

Later in her speech she returned to the example of the work of the Catholic Church and persons with mental retardation. She gave the example of a child with

Down syndrome who had been tested, diagnosed, and given every opportunity for the best skill training. In her early teens, however, the child was given religious instruction, and Mead described the change that took place in the girl's life in terms of "wholeness." She said that at the same time the girl "became Catholic, she became a human being in a way that she had not been one before. . . . I think that what happened on the secular side with this little girl was that for the first time she met a situation where people were willing to teach her the *whole* instead of saying, 'you are defective and you can only learn a part'" (Mead, 1959, p. 260).

Mead concluded her address to the AAMD by elaborating on the concept of education for "wholeness." She distinguished between societies where everyone participates in all aspects of the culture (e.g., Samoa) and segmented, socially stratified societies that no longer attempt to teach the "whole" to all people (e.g., the United States). She emphasized that what makes for a culture of full participants are genuine opportunities for most people to learn how to wholly participate. She warned of the "risks of complicating sections of our culture so much that we define them as things most people can't learn" (pp. 258-259).

Margaret Mead's insights, unfamiliar to most people concerned about mental retardation and previously overlooked in my own reading of her work, added new meaning to my understanding that, in order for people with what we call mental retardation to be genuinely included in our culture, we must strive to make accessible to them the essential "wholeness" of citizenship (Smith & Johnson, 1997). That part of people that we have referred to as mental retardation, feeble-mindedness, or some other diagnostic term must no longer be allowed to overshadow the "wholeness" of individuals.

THE REJECTION OF TOPOLOGICAL THINKING: ABANDONING THE "STOCKS" OF MENTAL RETARDATION

Steven Gelb recently examined the persistence of typological thinking in the field of mental retardation (Gelb, 1997). Typological thinking is the belief that individual differences diverge into underlying types or essences. Gelb explained that definitions of mental retardation, regardless of their differences or particulars, have been founded on the assumptions of typological thought. The axis or core of the field of mental retardation is the assumption that somehow there is an "essence of mental retardation" that eclipses all of the individual differences that characterize the people who are described by the term.

A glance at the panoply of causes that are associated with mental retardation is illustrative of the allure and power of typological thinking. In 1992 the AAMR listed more than 350 conditions in which mental retardation occurs (Lukasson et al., 1992). This list of etiologies does not, of course, take into account the varying degrees or

specific types of disabilities associated with these etiologies. If these variables were taken into account, the contexts and expressions of what is called mental retardation would be staggering. The only "glue" that holds mental retardation together as a category is the typological notion that there is some underlying essence to the characteristics and needs of the people identified by this term. Clearly, mental retardation is a term used for an aggregation of life conditions. The only rationale for this aggregation has been the typological definitions that Gelb describes.

In his book *Wayward Puritans*, Kai Erikson (1965) observed that the amount of punishable deviancy that was recorded in 17th-century Quaker New England corresponded neatly with the supply of stocks and whipping posts that were available. If a community had an ample supply of stocks, it convicted and punished a corresponding number of persons for their deviations from the norm. If stocks were in short supply, the rate of deviations detected and punished in that community dropped. Erikson argued that it is a simple logistic fact that the degree of deviance that a community perceives and acts on is largely determined by the kinds of equipment it uses to detect and manage different forms of deviancy. The magnitude of deviation found in a community is at least in part, then, a function of the size and complexity of its social control mechanisms (Erikson, 1965).

Mechanisms of social control will, as has been discussed previously, be influenced by the "felt necessities" of the time and place. They will also be influenced, however, by the tolerance or intolerance for certain traits or for degrees of certain attributes. In *The Rules of Sociological Method*, Emile Durkheim (1895/1964) invited his readers to

imagine a society of saints, a perfect cloister of exemplary individuals. Crimes, properly so called, will there be unknown; but faults which appear venial to the layman will create there the same scandal that the ordinary offense does in ordinary consciousness. If, then, this society has the power to judge and punish, it will *define* these acts as criminal and will treat them as such. (p. 63)

During the 20th century in the United States, the number of individuals defined as being mentally retarded has shifted dramatically. As the emphasis on intelligence test performance has changed, there have been dramatic fluctuations in the demographics of mental retardation. The same is true of the other changes in the accepted definitions of mental retardation. In a sense we have established changing patterns of "intellectual and adaptive saintliness" and have thereby created the less than "exemplary individuals" that society has the power to define as "retarded." In this way, and usually with the best of intentions, we have created the social equivalent of the Puritans' stocks. We have created mechanisms of social control waiting to be used.

In his book, *Miles To Go: A Personal History of Social Policy*, Daniel Patrick Moynihan (1996) included a chapter titled "Defining Deviancy Down." In that chapter Moynihan described three ways that various forms of social deviance have been redefined. Moynihan commented that *altruistic redefinitions* may be the attempts of "good" people to do the "right" thing. These attempts, however, sometimes lead to losses that have a dramatic impact on those who are redefined (Moynihan's example is deinstitu-

tionalization). *Opportunistic redefinitions*, according to Moynihan, may result in the growth of the numbers of people defined as deviant and an increase in the resources and power available to those who "control" the deviant population affected. Moynihan described a *normalizing redefinition* as a form of denial. The result of such a denial may be the neglect of the real needs of the persons who have been redefined. Moynihan's analysis of redefinitions makes evident the caution that must be used in redefining mental retardation.

Perhaps it is time, however, to abandon the term mental retardation, it may, in fact be a manifestation of typological thinking that inevitably creates a false and unhelpful categorization of people with very diverse needs and characteristics. Perhaps even the most recent AAMR definition of mental retardation does not go far enough to diminish the tendency of society to place people in the social stocks we create.

As we consider the alternatives for conceptualizing the needs of people currently referred to as having mental retardation, however, it may be helpful to use Moynihan's redefinition model as a way of asking ourselves questions about what changes in terms, categories, and definitions can mean in the lives of individuals and families. (What are the altruistic implications of redefinition?) We must also ask ourselves what redefining mental retardation might mean for the resource allocations and the provision of services to people who need them. (What are the opportunistic redefinition consequences?) Finally, we must consider the impact of a definition in terms of the dichotomies of need versus norm. How much segregation is necessary to meet needs? How much service is justified with the risk of stigma associated with these services? How can we achieve a balance between the need for assistance and the value of independence? These are the questions associated with a normalizing redefinition of mental retardation.

With the approach of the millennium, however, the time is overdue for a fundamental questioning of the concepts, terms, and practices associated with mental retardation. The millions of people with the myriad of developmental disabilities that have been subsumed under that term deserve this questioning of the manner in which they are being regarded and treated. A disassembling of the aggregation that mental retardation is may enhance our vision of what it should be.

REFERENCES

- Blatt, B. (1987). *The conquest of mental retardation*. Austin, TX: PRO-ED.
- Clausen, J. A. (1972). The continuing problem of defining mental deficiency, *Journal of Special Education*, 6, 97-106.
- Dickens, C. (1842). *American notes*. London: Oxford University Press.
- Doll, E. A. (1941). The essentials of an inclusive concept of mental deficiency. *American Journal of Mental Deficiency*, 46, 214-229.
- Durkheim, E. (1964). *The rules of sociological method* (A. Birenbaum & H. Lesieur, trans.). New York: The Free Press. (Original work published 1895)
- Edgerton, R. B. (1993). *The cloak of competence: Revised and updated*. Berkeley: University of California Press.

- Erikson, K. T. (1965). *Wayward puritans*. New York: Wiley.
- Ferguson, P. M. (1994). *Abandoned to their fate: Social policy and practice toward severely retarded people in America, 1820-1920*. Philadelphia: Temple University Press.
- Foner, P. (1967). *Helen Keller: Her socialist years, writings and speeches*. New York: International Publishers.
- Gallaher, D. (1995). *Voices for the mad: The life of Dorothea Da*. New York: Free Press.
- Gelb, S. A. (1997). The problem of typological thinking in mental retardation. *Mental Retardation*, 35, 448-457.
- Gibbons, F. X. (1985). Stigma perception: Social comparison among mentally retarded persons. *American Journal of Mental Deficiency*, 90, 98-106.
- Gitter, E. (1991). Charles Dickens. *Dickens Quarterly*, 8, 162-168.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.
- Greenspan, S. (1995). Selling DSM: The rhetoric of science in psychiatry. *American Journal on Mental Retardation*, 99, 683-685.
- Grossman, H. J. (1973). *Classification in mental retardation*. Washington, DC: American Association on Mental Deficiency.
- Grossman, H. J. (Ed.). (1977). *Manual on terminology and classification in mental retardation*. Washington, DC: American Association on Mental Deficiency.
- Grossman, H. J. (1983). *Classification in mental retardation*. Washington, DC: American Association on Mental Deficiency.
- Heber, R. F. (1959). A manual on terminology and classification in mental retardation. Monograph Supplement, *American Journal of Mental Deficiency*, 62.
- Heber, R. F. (1961). A manual on terminology and classification in mental retardation. Monograph Supplement, *American Journal of Mental Deficiency*, 63.
- Holmes, O. W. (1881). *The common law*. Boston: Little, Brown.
- Howe, S. (1893). *The education of Laura Bridgman*. Boston: Perkins Institute.
- Howe, M., & Hall, F. (1904). *Laura Bridgman: Dr. Howe's famous pupil and what he taught her*. London: Hodden & Stoughton.
- Jacobson, J., & Mulick, J. (1993). APA takes a step forward in professional practice. *Psychology in Mental Retardation and Developmental Disabilities*, 19, 4-8.
- Keller, H. (1915, December 18). Physicians' juries for defective babies. *The New Republic*, pp. 173-174.
- Kuhn, T. (1962). *The structure of scientific revolutions*. Chicago: The University of Chicago Press.
- Lukasson, R., Coulter, D. L., Polloway, E. A., Reiss, S., Schalock, L. L., Snell, M. E., Spitalnik, D. M., & Stark, J. A. (1992). *Mental retardation: Definition, classification, and systems of supports*. Washington, DC: American Association on Mental Retardation.
- MacMillan, D., Gresham, F., & Siperstein, G. (1993). Conceptual and psychometric concerns about the 1992 AAMR definition of mental retardation. *American Journal on Mental Retardation*, 98, 325-335.
- MacMillan, D., Gresham, F., & Siperstein, G. (1995). Heightened concerns over the 1992 AAMR definition: Advocacy versus precision. *American Journal on Mental Retardation*, 100, 87-97.
- Mead, M. (1928). *Coming of age in Samoa: A psychological study of primitive youth for Western civilization*. New York: William Morrow.
- Mead, M. (1959). Research cult: or cure? *American Journal on Mental Deficiency*, 64, 253-164.
- Michaelson, R. (1993). Tug-of-war is developing over defining retardation. *APA Monitor*, 24(5), 34.
- Moynihan, D. P. (1996). Miles to go: A personal history of social policy. Cambridge, MA: Howard University Press.
- Pernick, M. (1996). *The black stork: Eugenics and the death of "defective" babies in American medicine and motion pictures since 1915*. New York: Oxford University Press.

- Sarason, S. (1985). *Psychology and mental retardation: Perspectives in change*. Austin, TX: PRO-ED.
- Schalock, R., Coulter, D., Polloway, E., Reiss, S., Snoll, M., Spitalnik, D., & Stark, J. (1994). The changing conception of mental retardation: Implications for the field. *Mental Retardation*, 32, 181-193.
- Smith, J. D. (1985). *Minds made feeble: The myth and the legacy of the Kallikaks*. Rockville, MD: Aspen.
- Smith, J. D. (1987). The other voices: *Profiles of women in the history of special education*. Seattle: Special Child Publications.
- Smith, J. D., & Anton, M. (1997). Laura Brklgman, mental retardation, and the question of differential advocacy. *Mental Retardation*, 35, 398-401.
- Smith, J. D., & Johnson, G. (1997). Margaret Mead and mental retardation: Words of understanding, concepts of inclusive-ness. *Mental Retardation*, 35, 306-309.
- Smith, J. L., & Nelson, K. (1989). *The sterfeation of Carrie Buck*. Far Hill, NJ: New Horizon Press.
- Trent, J. W. (1994). *Inventing the feeble mind: A history of mental retardation in the United States*. Berkeley: University of California Press.