Familial retardation

Also called sociocultural or cultural-familial retardation, mild mental retardation attributed to environmental causes and generally involving some degree of psychosocial disadvantage.

The majority of persons suffering from mental retardation fall into the category of familial retardation rather than that of clinical retardation, which usually has neurological or other organic causes. Persons with familial retardation typically have IQs ranging from 55-69 and show no signs of physical disability. Environmental causes thought to contribute to familial retardation include the quality of the mother’s prenatal care, maternal and child nutrition, family size, the spacing of births within a family, disease, and health risks from environmental toxins such as lead. The 1994 publication of The Bell Curve, an analysis, by Richard J. Herrnstein and Charles Murray, of the relative importance of heredity and environment in determining IQ scores, and the 1995 release of the most in-depth study to date on retardation among school children both renewed public interest in familial retardation and its causes.

Familial retardation is usually not detected until a child enters school and has academic difficulties, at which point the teacher recommends psychological evaluation. Unlike the parents of clinically retarded children, who generally seek out help for their youngsters, the parents of those with familial retardation may take offense when their children are labeled mentally retarded and deny that there is a problem, especially since their children are often able to function competently in their daily lives outside school. Some studies have shown that educators are more likely to classify poor and/or minority children as mentally retarded, while labeling white middle-class children with comparable IQ scores as learning disabled. Other critics have pointed out that familial retardation may be diagnosed in children who are simply unprepared to cope with the demands of school because of cultural and linguistic isolation.

Familial retardation may be reduced by nutritional, health, and educational intervention at an early age. In a study conducted in the 1970s, educators selected mother-child pairs from among a group of women with IQs under 75 living in the poorest section of Milwaukee, Wisconsin, while establishing a control group of mothers in the same neighborhood with IQs over 100. For the first five years of the children’s lives, the targeted group of mothers and their children received instruction in problem-solving and language skills, as well as counseling to motivate them to learn and succeed. The mothers and children in the control group received no form of environmental enrichment. At the age of five, the children in the target group had IQ scores averaging 26 points higher than those of the children in the control group. At the age of nine, their average IQ was 106 (slightly above the universal norm of 100), while that of the other children was only 79. (Later results, however, were somewhat disappointing, as the mothers’ motivation to continue the program became difficult to maintain over the long term.)

In 1995, an Atlanta study conducted jointly by the Centers for Disease Control and Prevention and Emory University found important new evidence linking mild retardation to social and educational deprivation. It was found that 8.4 out of every 1,000 10-year-olds were mildly retarded (defined as an IQ of 50-70), while 3.6 of every 1,000 suffered severe retardation due to such conditions as cerebral palsy or Down syndrome. The incidence of mild retardation was 2.6 higher in blacks than whites, although this difference was halved when socioeconomic factors were taken into account. Children of all races were four times as likely to be mildly retarded if their mothers had not finished high school. The incidence of mental retardation was also slightly higher for children of teenage mothers. The Atlanta study also confirmed earlier claims that teachers are more likely to seek IQ testing for minority children from poor families.
Based on the findings of this survey, the federal government launched a pilot program to improve health and education for disadvantaged mothers and children, with special emphasis on providing a more intellectually stimulating home environment for at-risk youngsters through reading programs and other activities.

As adults, socioculturally retarded individuals live in a variety of settings, including their parental homes, group homes, and their own independent residences. Very few are institutionalized. Most make a satisfactory adjustment to adult life in their communities, although their adjustment in early adulthood is likely to be more difficult than that of the average person. Often they must learn from their own life experiences lessons that others learned (or at least were introduced to) at home. Eventually, however, most become responsible and self-supporting members of their communities with the ability to meet adult responsibilities and commitments.

Further Reading

Family size

The size of a family has a significant effect on the interrelationships among its members and can play a major role in the formation of a child's personality.

Family size is a significant factor in child development, but must be considered as only one part of a larger picture, however. Other factors, such as the parents’ personality traits, and the gender and spacing of the children, contribute significantly to the formation of a child’s personality. Children of large families have a greater opportunity to learn cooperation at an early age than children of smaller families as they must learn to get along with siblings. They also take on more responsibility, both for themselves and often for younger brothers and sisters. In addition, children in large families must cope with the emotional crises of sibling rivalry, from which they may learn important lessons that will aid them later in life. This factor, however, may also be a disadvantage; either the older child who was “de-throned” from a privileged position or the younger child who is in the eldest child’s shadow may suffer feelings of inferiority. Children in large families tend to adopt specific roles in order to attain a measure of uniqueness and thus gain parental attention.

Children in small families receive a greater amount of individual attention and tend to be comfortable around adults at an early age. They may also be overprotected, however, which can result in dependence, lack of initiative, and fear of risk, and the increased parental attention may also take the form of excessive scrutiny and pressure to live up to other people’s expectations. Researchers have found that only children are often loners and have the lowest need for affiliation. They tend to have high IQs and are successful academically. However, only children have also been found to have more psychological problems than children from larger families.

Family therapy

The joint treatment of two or more members of the same family in order to change unhealthy patterns of communication and interaction.

Family therapy is generally initiated because of psychological or emotional problems experienced by a single family member, often a child or adolescent. These problems are treated as symptomatic of dysfunction within the family system as a whole. The therapist focuses on the interaction between family members, analyzing the role played by each member in maintaining the system. Family therapy can be especially helpful for dealing with problems that develop in response to a particular event or situation, such as divorce or remarriage, or the birth of a new sibling. It can also be an effective means to draw individuals who feel threatened by individual therapy into a therapeutic setting.

Family therapy has a variety of origins. It is related to the long-standing emphasis of psychoanalysis and other psychodynamic approaches on the central role that early family relationships play in the formation of personality and the manifestation of psychological disorders. Family therapy also grew out of the realization that progress made by patients staying in treatment centers was often reversed when they returned to their families. As a result, a number of therapists became dissatisfied treating clients individually with no opportunity to actively address the harmful family relationships that were often the source of their clients’ problems.

Family therapy, either alone or in conjunction with other types of treatment, has been effective in the treatment of children suffering from a variety of problems, including anxiety, enuresis (bed-wetting), and eating disorders, and also in working with victims of child abuse. In addition to alleviating the child’s initial complaint and improving communication within the family