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Original Research Paper

Aggression: A Source of Social Unacceptability of the Person with Intellectual Disability

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ABSTRACT

Aggressive behaviour in people with Intellectual Disability (ID) appears to present with greater frequency comparing to their counterpart without ID. Because of this deficit the ability to learn language processing, judgement & analytical skills and like cognitive skills are impaired in individual with ID which may have indirect effect on their social recognition and thus have a profound negative effect on their self-esteem. Aggression can result from chronic frustration of self-esteem and its chief ingredients – intimacy, success & autonomy. As a vicious cycle, aggressive individuals with ID commonly experience more rejection & social isolation than their non-aggressive counterpart. Though there are studies on aggression of persons with MR but little studies are available which have tried to find out whether this aggression again has any effect on their cognitive and affective components. So, accepting the existing cognitive impairment, the aim of the present study is to see the effect of aggression on cognitive ability & affective quality of the persons with ID. The study was conducted on 8 children & adolescents (N=8, age 6 to 9yrs.and 13 to 16yrs) with ID (matched by level of impairment). They were assessed on the adapted & translated version of CHIA scale and BASIC MR (PART A & B). From the result it is evident that low aggressive individuals show less problem behaviour & their cognitive functioning is better than their high aggressive counterpart. Moreover, high aggressive adolescents show more problem behaviour than their children counterpart. So, it can be assumed that if a proper aggression control training module can be developed & successfully administered to these persons the so-called problem behaviour of the persons with intellectual impairment would be less which may help them to develop their self esteem& paves the way of a better acceptance by the society.

Keywords: *Aggression, Mental Retardation, Social Rejection, Cognition, Problem Behaviour.*

The term 'Anger' like other feeling or emotion, not only has quality and quantity but also has some form. Qualitatively, it is unpleasant yet categorically different from other discrete

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emotions such as sadness and fear. Quantitatively, it varies on a continuum of intensity or arousal from low levels called 'annoyance' to high levels called 'rage'. Additionally, anger can assume the form of an emotion, a mood, or a temperament, depending on whether it is phase, tonic, or cyclic.

The physical effects of anger increased heart rate, blood pressure and levels of adrenaline and nor adrenaline. Some view anger as part of the fight or flight brain response to the perceived threat of harm. Anger becomes predominant feeling behaviorally, cognitively and physiologically when a person makes the conscious choice to take action immediately stops the threatening behavior of another outside force.

The external expression of anger can be found in facial expression, body language, physiological responses and at times in public acts of aggression. Modern psychologists view anger as a primary natural & mature emotion experienced by all humans at times, and as something that has functional value for survival.

Thus, an ***operational definition of anger*** has given by Averill in 1982 as "A conflictive emotion that, on the biological level, is related to aggressive systems, and even more important, to the capacities for cooperative social living, symbolization, and reflective self-awareness; that on the psychological level, is aimed at the correction of some appraised wrong; and that, on the Socio-cultural level, functions to uphold accepted standards of conduct". The definition of anger is also couched within the context of interpersonal relations and social norms. Finally, the definition hints at the predominant avenues through which anger is expressed.

Emphasizing the cognitive structure of emotions, Ortony et al(1988) propose that anger is a compound emotion linking an attribution about the action of an agent to an assertion about one's wellbeing. Specifically, disapproval of someone else's blameworthy action is combined with displeasure at the undesirable consequences of such action.

DEFINITION OF MENTAL RETARDATION

The conceptualization of mental retardation includes deficits in cognitive abilities as well as in behaviors required for social and personal sufficiency, known as adaptive functioning. According to the DSM-IV-TR, mental retardation is defined as significantly sub average general intellectual functioning resulting in, or associated with, concurrent impairment in adaptive behavior and manifested during the developmental period, before the age of 18.

The American Association on Mental Retardation (AAMR), arguably the leading professional organization in the field of mental retardation, offered the following definition of mental retardation in 2002 in its 10th edition of the AAMR reference manual on definition and terminology (Luckasson, Northwick-Duffy, Bunting, Coulter, Craig, Reeve, et al.):

Mental retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18.

This definition has been widely adopted. It forms the basis for the definition included in IDEA, the Individuals with Disabilities Education Act of 1990.

Much research indicates that mental retardation frequently is accompanied by problems of aggression (Mullick et al., 1991), anxiety, and fears (McNally,1991). One of the unpleasant feelings important to adjustment is anger. Because anger seeks its own discharge and can lend itself to various forms of aggression, its means of expression is important to the quality of our adjustment. Parenthetically, problems of controlling anger and expressing it in socially acceptable means often create adaptive problems for persons with mental retardation. Major patterns of aggression are found in from 10% to 28% of individuals with retardation (Reid & Parsons, 1992).

Factors of Aggression:

Biological factors themselves may contribute to aggression by heightening levels of irritability. Thus, exposure to confusing situation, crowding, or noise can heighten irritability. Aggression may also be associated with physical pain, with seizures (as in temporal lobe or partial complex seizures), and as a side effect of medication.

In the psychological realm, aggression can result from chronic frustration of self-esteem and its chief ingredients- intimacy, success, and autonomy. Mental retardation appears to particularly threaten our need for intimacy, as individuals with this disability commonly experience rejection and social isolation.

Persons are discomforted by awareness of their inadequacies- it is inherent in human being. Experiences of failure are inevitable but with reasonably healthy resources (capacities); they are more than compensated for by experiences of success, of “can do”. But disability of whatever kind impedes the capacity to be successful in at least some of the valued roles in the culture. Certainly, retardation renders the individual more vulnerable to the frustrations associated with mental and even physical challenges. The effect of heightened irritability and, if chronic, leads to both a withdrawal from situation in which failure is expected and a lack of willingness to persist at tasks at which some effort is required. For example, a mentally retarded child who is not able to cope with the situation may react with aggression in the form of temper tantrums.

The third ingredient of self-esteem, autonomy, also can be a source of frustration in retardation. This is commonly heard of the adolescent with retardation who resents the freedom and autonomy granted to younger nondisabled siblings. More generally, adolescent rebellion, whether in the retarded or non-retarded child, illustrates a common reaction to the ambivalent status of youth in society- neither child nor adult. Adolescent rebellion represents

aggression in the service of achieving greater control of one's life, greater autonomy. The implication of personality model is that chronic need deprivation leads to the persistent experience of unpleasant emotional states, and it is their forms of expression that constitute "maladaptive" forms of behavior.

Because of intellectual deficits, mentally retarded individuals' ability to learn is impaired. Language processing & logical thinking deficits are often present, as are impairments in reasoning &problem-solving abilities. Mental retardation interferes with language processing, impairs judgment & analytical skills. Some researchers have postulated that developmental delays in cognitive ability (low IQ) may affect social development primarily by delaying the acquisition of positive social skills, contributing to social withdrawal and poor peer relationships (Guralnick & Groom, 1985). It is reasonable to postulate that cognitive delays (low IQ), which involve deficits in knowledge and reasoning skills, might interfere primarily with the acquisition of positive social skills, contributing to deficits in communication and pro social play skills and corresponding high rates of disruptive and aggressive behavior (Pope & Bierman, 1999).Aggression in a proportion of people with intellectual disabilities is often assumed to be due to social – cognitive deficits. To conclude mental retardation relates to basic & broad impairments in cognitive functioning that affect the individual's ability to learn, processing of information& retain information across the life.

Mental retardation often affects people emotionally as well as intellectually. Many mentally retarded individuals' functions on an emotional and social level that is below what is appropriate for their age. The emotional immaturity is often considered as an endearing aspect of mentally retarded individuals personalities. Aggression and related disruptive acts represent the most frequently occurring behavioral challenges of persons with intellectual disabilities (ID) (Eyman & Call, 1977; Jacobson, 1982; Schroeder, Rojahn, & Olenquist, 1991). Even though aggression occurs in a social context and is maintained to a major extent by social contingencies, medical, genetic, psychiatric, neuropsychiatric, and psychological conditions also are reported to represent significant contributing influences (Barnhill, 1999; Gardner, 2002a; Sheard, 1984).Some common behavioral traits associated with mental retardation such as low tolerance & sometimes become aggressive & may engage in self injurious behaviour. Individuals who have mental retardation struggle with understanding social rules like taking turns & waiting until someone else finishes speaking. Maladaptive behaviour among persons with mental retardation predicts academic problems, failure in community living arrangements, frequent moves, social isolation and rejection, and reduced employment prospects (Borthwick-Duffy & Eyman, 1990; Bruininks, Hill, & Morreau, 1988; Pearson et al., 2000).Aggressive behavior in individuals with ID can result in a number of deleterious effects. The presence of aggressive and destructive behavior in individuals with ID has been shown to significantly affect their relationships with others, as others will limit interaction with these individuals in order to avoid or reduce the potential for physical harm (Danforth & Drabman, 1989). Hanley, Iwata, and McCord (2003) reported that 25.3% of studies found that problem behaviours were maintained by attention, 15.8% by non-social,

and 10.1% by access to tangible items. In addition, 14.6% of studies identified multiple functions in that participants engaged in problem behaviors for more than one reason.

Though there are no dearth's of studies on aggression of persons with MR but little studies are available which have tried to find out whether this aggression again has any effect on their cognitive and affective components. So, accepting the existing cognitive impairment, the aim of the present study is to see the effect of aggression on cognitive ability & affective quality (as expressed by problem behavior of the persons with ID.

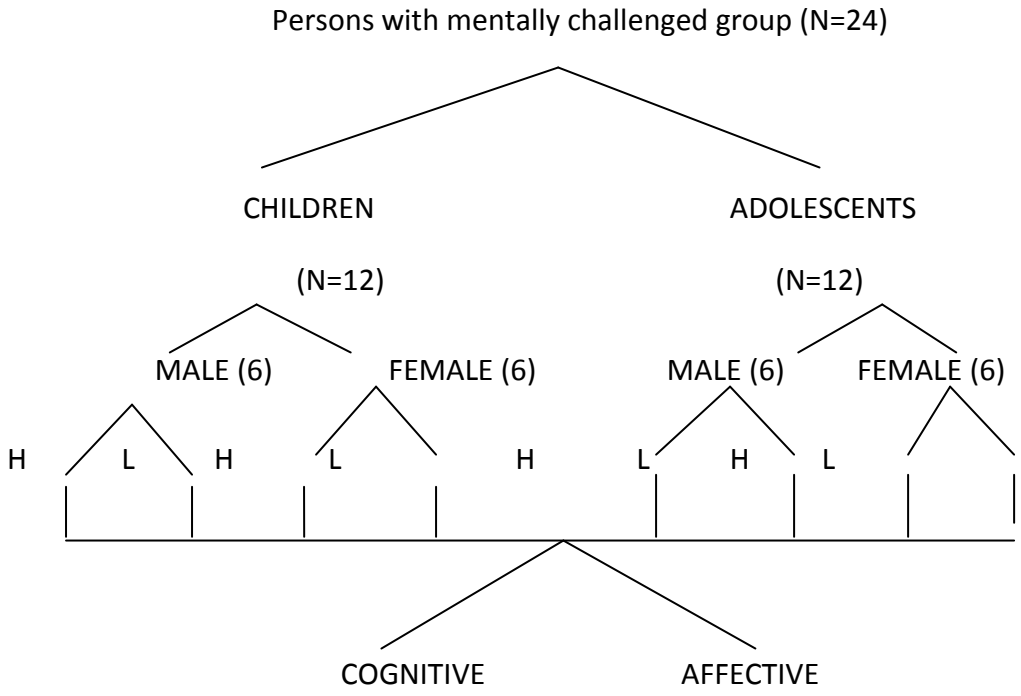
Objectives:

1. To see the effect of aggression on
   1a) cognitive ability of mentally retarded children
   1b) cognitive ability of mentally retarded adolescent
2. To see the effect of aggression on
   2a) affective quality of mentally retarded children
   2b) affective quality of mentally retarded adolescent
3. To see the difference, if any, of aggression between children and adolescent with mental retardation
4. To see the difference, if any, of aggression between male and female with mental retardation.

METHODOLOGY

Sample:

Total 24 mentally challenged children & adolescents ages range from 6 to 9 yrs. and 13 to 16 yrs. All the subjects fall under Mild Mental Retardation category.



H= High Aggression & L= Low Aggression

Inclusion Criteria*:*
Children & adolescents with mild mentally challenged as assessed by intelligence & adaptive functioning are to be selected.

Exclusion Criteria:

1. MR with any other disability.
2. MR with any other clinically significant physical & mental disease.

Organismic Variables

- Age – Child & Adolescent
- Sex – Male & Female
- Level of Aggression will be measured by
  Adapted & translated version of CHIA scale which was originally developed by NELSON & FINCH in the year 2000.

Dependent Variable
Measured by

1. Under BASIC MR (PART A) domain no. III- LANGUAGE, IV- READING-WRITTING, V-NUMBER-TIME, measure the **cognitive** ability of mild category of mentally challenged children & adolescents.
2. BASIC MR (PART B) measures the **problem behavior** of mild category of mentally challenged children & adolescents.

Procedure
Scale adaptation & translation: The original CHIA (Children Inventory of Anger) scale was developed by Nelson & Finch in the year 2000. Most of the items in this scale are not applicable for Indian average intelligence group of children age range 6 to 16yrs.Moreover, the sample of the present study is belonging to mentally retarded group. so, scale adaptation and translation in Bengali is necessary for the study. The steps are given below following the rules & regulation.

1. As the original CHIA scale is self-inventory but the population of the present study is mental retardation who may not be able to inform about their anger/aggression, items were translated following 'Backward-Forward' method and adapted as the questionnaire can be administered to the parents/care-giver of the person with MR about their wards in Indian context.
2. Relevance judgment from ten respectable & knowledgeable judges were collected for adapted items in 5-point rating scale where 5 denotes most relevant,4 denotes somewhat relevant, 3 denotes relevant, 2 denotes slight relevant, 1 denotes not at all relevant.
3. The mean values of 10 judges were computed for each item separately. Items with mean values more than '3' and SD less than '1' were selected. 1 item was discarded.

4. The selected 37 items were administered to 100 parents having wards with mental Retardation.
5. Item total correlations were computed and 'r' value more than '0.3' was selected as criterion for item selection.
6. In this way item no. 8,11,12,13,15,16,22,23,29,32 were rejected.
7. Internal consistency reliability of the 27 items was found to be .825 measured by ***Cronbach's' alpha.***

Norm

Lowest total score of 27 items = 56
Highest total score of 27 items = 92
Mean = 79.03
SD = 8.77
Average aggression = Mean + SD(79+8) = 87
Mean - SD(79-8) = 71
Average aggression = 71 – 87

Finally, after the adaptation, translation, and norm procedure the data was collected from 24 mentally retarded children at Govt. hospital. Adapted & translated version of CHIA scale and BASIC MR (PART B) were administered to the parents of 24 persons with mental retardation to see their level of aggression and measure their problem behavior. Only 3 domains under BASIC MR (PART A) that measured the cognitive ability were administered to the 24 persons with mental retardation.

DATA & RESULT

DATA OF MALE, ADOLESCENT, LOW AGGRESSIVE MILD MR

TABLE - 1

SERIAL NO.	SEX	AGE (13 to 16)	CHIA SCORE	CATEGORY	BASIC MR(B)	LANG	R. W	N.T.
1	M	A	65	LOW AGG.	6	75.50	61.5	51
2	M	A	60	LOW AGG.	20.36	45.50	30.5	18
3	M	A	57	LOW AGG.	12.56	66.56	55.5	49.5

DATA OF MALE, ADOLESCENT, HIGH AGGRESSIVE MILD MR

TABLE – 2

SERIAL NO.	SEX	AGE (13 to 16)	CHIA SCORE	CATEGORY	BASIC MR (B)	LANG	R. W	N. T
1	M	A	90	HIGH AGGRESSION	50.66	56.50	41.50	46.50
2	M	A	98	HIGH AGGRESSION	51.56	50.50	26.50	25.50
3	M	A	89	HIGH AGGRESSION	66.67	50	56.50	48.5

DATA OF FEMALE, ADOLESCENT, LOW AGGRESSIVE MILD MR

TABLE – 3

SERIAL NO.	SEX	AGE (13 to 16)	CHIA SCORE	CATEGORY	BASIC MR (B)	LANG	R.W	N.T
1	F	A	55	LOW AGGRESSION	28.84	64.50	55.55	52.50
2	F	A	63	LOW AGG.	20.38	50.50	42.50	28.50
3	F	A	62	LOW AGGRESSION	20	68.50	51.50	41

DATA OF FEMALE, ADOLESCENT, HIGH AGGRESSIVE MILD MR

TABLE – 4

SERIAL NO.	SEX	AGE (13 to 16)	CHIA SCORE	CATEGORY	BASIC MR (B)	LANG	R.W	N.T
1	F	A	92	HIGH AGGRESSION	69.56	60	46.50	54
2	F	A	94	HIGH AGGRESSION	59.56	45	38.50	24.50
3	F	A	89	HIGH AGGRESSION	65.56	40.50	28.50	15

DATA OF MALE, CHILDREN, LOW AGGRESSIVE MILD MR

TABLE – 5

SERIAL NO.	SEX	AGE (6 to 9)	CHIA SCORE	CATEGORY	BASIC MR (B)	LANG	R.W	N.T
1	M	C	65	LOW AGGRESSION	28.76	75.50	60	50.50
2	M	C	50	LOW AGGRESSION	4	65	50.50	45
3	M	C	60	LOW AGGRESSION	15	62.50	55.50	51

DATA OF MALE, CHILDREN, HIGH AGGRESSIVE MILD MR

TABLE – 6

SERIAL NO.	SEX	AGE (6 to 9)	CHIA SCORE	CATEGORY	BASIC MR (B)	LANG	R.W	N.T
1	M	C	101	HIGH AGGRESSION	60.66	55.50	35	42
2	M	C	94	HIGH AGGRESSION	68.67	58	27	20
3	M	C	90	HIGH AGGRESSION	58	48	45.50	40.50

DATA OF FEMALE, CHILDREN, LOW AGGRESSIVE MILD MR

TABLE – 7

SERIAL NO.	SEX	AGE (6 to 9)	CHIA SCORE	CATEGORY	BASIC MR (B)	LANG	R.W	N.T
1	F	C	58	LOW AGGRESSION	32	55.00	45	30
2	F	C	67	LOW AGGRESSION	27.30	49.50	25.50	12
3	F	C	65	LOW AGGRESSION	8	58	40	25

DATA OF FEMALE, CHILDREN, HIGH AGGRESSIVE MILD MR

TABLE – 8

SERIAL NO.	SEX	AGE(6 to 9)	CHIA SCORE	CATEGORY	BASIC MR (B)	LANG	R.W	N.T
1	F	C	95	HIGH AGGRESSION	65.67	49	38.50	28
2	F	C	89	HIGH AGGRESSION	62.67	45	35.50	25
3	F	C	101	HIGH AGGRESSION	76.67	45	38	30

TABLE 1 – Table 1 showing the mean, standard deviation (SD) regarding level of aggression and the 'U' value of Basic MR part (B),Language, Reading Writing, Number Time, CHIA score.

Ranks				
	LEVELOFAGGRESSION	N	Mean Rank	Sum of Ranks
BASICMRB	5	12	6.50	78.00
	6	12	18.50	222.00
	Total	24		
LANGUAGE	5	12	16.33	196.00
	6	12	8.67	104.00
	Total	24		
READINGWRITTING	5	12	15.54	186.50
	6	12	9.46	113.50
	Total	24		
NUMBERTIME	5	12	13.92	167.00
	6	12	11.08	133.00

Ranks				
	LEVELOFAGGRESSION	N	Mean Rank	Sum of Ranks
	Total	24		
CHIASCORE	5	12	6.50	78.00
	6	12	18.50	222.00
	Total	24		

Test Statistics[b]					
	BASICMRB	LANGUAGE	READING WRITTING	NUMBER TIME	CHIASCORE
Mann-Whitney U	.000	26.000	35.500	55.000	.000
Wilcoxon W	78.000	104.000	113.500	133.000	78.000
Z	-4.162	-2.666	-2.112	-.983	-4.168
Asymp. Sig. (2-tailed)	.000	.008	.035	.326	.000
Exact Sig. [2*(1-tailed Sig.)]	.000[a]	.007[a]	.033[a]	.347[a]	.000[a]
a. Not corrected for ties.					
b. Grouping Variable: LEVELOFAGGRESSION					

TABLE 2 – Table 2 showing the mean, standard deviation (SD), and Kruskal Wallis Test of Basic MR part (B), Language, Reading Writing, Number Time, CHIA score value in respect of Age group.

NPar Tests

Descriptive Statistics					
	N	Mean	Std. Deviation	Minimum	Maximum
Bmr	24	40.7921	24.17207	4.00	76.67
Lang	24	55.8150	9.81058	40.50	75.50
Rw	24	42.9604	11.09782	25.50	61.50
Nt	24	35.5625	13.41099	12.00	54.00
Chia	24	77.0417	17.43928	50.00	101.00
aggression	24	5.5000	.51075	5.00	6.00
Age	24	3.5000	.51075	3.00	4.00

Kruskal-Wallis Test

Ranks			
	Age	N	Mean Rank
Bmr	3	12	13.00
	4	12	12.00

Ranks			
	Age	**N**	**Mean Rank**
	Total	24	
Lang	3	12	12.04
	4	12	12.96
	Total	24	
Rw	3	12	11.17
	4	12	13.83
	Total	24	
Nt	3	12	11.29
	4	12	13.71
	Total	24	
Chia	3	12	13.38
	4	12	11.62
	Total	24	
Aggression	3	12	12.50
	4	12	12.50
	Total	24	

Test Statistics[a,b]						
	bmr	**lang**	**Rw**	**nt**	**chia**	**Aggression**
Chi-Square	.120	.101	.854	.702	.369	.000
Df	1	1	1	1	1	1
Asymp. Sig.	.729	.750	.355	.402	.543	1.000
a. Kruskal Wallis Test						
b. Grouping Variable: age						

TABLE 3 – Table 3 showing mean, SD, and Krukal wallis test value of Basic MR part(B), Language, Reading-writing, Number time, and CHIA score in respect of Gender.

NPar Tests

Descriptive

	N	**Mean**	**Std. Deviation**	**Minimum**	**Maximum**
Bmr	24	40.7921	24.17207	4.00	76.67
Lang	24	55.8150	9.81058	40.50	75.50
Rw	24	42.9604	11.09782	25.50	61.50
Nt	24	35.5625	13.41099	12.00	54.00
Chia	24	77.0417	17.43928	50.00	101.00
aggression	24	5.5000	.51075	5.00	6.00
Gender	24	1.5000	.51075	1.00	2.00

Kruskal-Wallis Test

Ranks			
	Gender	**N**	**Mean Rank**
Bmr	1	12	10.92
	2	12	14.08
	Total	24	
Lang	1	12	14.92
	2	12	10.08
	Total	24	
Rw	1	12	14.00
	2	12	11.00
	Total	24	
Nt	1	12	14.67
	2	12	10.33
	Total	24	
Chia	1	12	12.25
	2	12	12.75
	Total	24	
aggression	1	12	12.50
	2	12	12.50
	Total	24	

Test Statistics[a,b]

	Bmr	**lang**	**rw**	**nt**	**chia**	**Aggression**
Chi-Square	1.203	2.812	1.081	2.256	.030	.000
Df	1	1	1	1	1	1
Asymp. Sig.	.273	.094	.298	.133	.862	1.000

a. Kruskal Wallis Test

b. Grouping Variable: gender

DISCUSSION

Major patterns of aggression are found in from 10% to 28% of individuals with retardation. In case of mentally retarded children aggression is viewed as a response to the frustration of basic needs, both biological and psychological. These children's inadequacies in daily living skill, se4lf help, self-care, safety, social awareness, and inappropriate emotional expression to the particular situation may fuels aggression because due to these inadequacies they may get rejection or social isolation. From, various studies it is seen that these children may exhibit excessive problem behaviour. Aims of the current study is to see the effect of aggression on cognitive ability and affective quality (as expressed by problem behaviour) of mentally retarded children and adolescents. The result table 1 reveals that the mean rank value of Basic MR Part B of low aggressive individuals is found to be 6.5 and the mean rank value is found

to be 18.5 in case of high aggressive individuals. From the mean rank value of language domain of low aggressive individuals is found to be 16.33 and 8.67 for the high aggressive individuals. It means low aggressive individuals do better in cognitive domain than high aggressive individuals. From the mean rank value of reading ability and number time domain of low aggressive individuals is found to be 15.54, 13.92 & 9.46, 11.08 for the high aggressive individuals. Here from the result table it can be suggested that low aggressive individuals do better in reading writing and number time domain than high aggressive individuals.

The 'U' test value is found be .007, .033 & .347 i.e., <.05 values in language, reading writing & number time domain, it means there is a significant relationship between aggression & cognitive ability in case of MR individuals.

The 'U' test value of Basic MR Part B & CHIA score is found to be .000 that is <.01 which suggest that there is a significant effect of aggression on affective quality (as expressed by problem behavior) of MR individuals.

From the Kruskal Wallis test at result table 2 it can be suggested that there is no significant difference of aggression between children and adolescents with MR.

From the result table 3 it can be suggested that there is no significant difference of aggression between male and female with MR.

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