INTRODUCTION TO MENTAL RETARDATION

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Introduction

Mental retardation is one of the most widely recognized and most easily misunderstood areas of special education. It is widely recognized in that most people think of a visible form of retardation such as Down syndrome. However, those with Down syndrome are not the only ones affected by this handicapping condition. It is often misunderstood, due in part to changing definitions and trends in educating these students. Understanding the definitions, trends, and programs related to mental retardation may help to clarify who these young people are and the approaches taken to help them develop to their fullest potential.

Definitions and Trends

During the past forty-eight years, the definition of mental retardation has undergone seven official changes as recognized by the American Association on Mental Retardation (AAMR) (Hallahan & Kauffman, 1994). In 1961 an IQ score of 85 was recognized as the upper cut-off for mental retardation (Robinson, Patton, Polloway, & Sargent, 1989). In 1983 the revised definition set the upper IQ limit as 70, but as a guideline only. In 1992, the AAMR developed the following definition:

> An individual is considered to have mental retardation based on the following three criteria: intellectual functioning level (IQ) is below 70-75; significant limitations exist in two or more adaptive skill areas; and the condition is present from childhood (defined as age 18 or less) (The Arc, 1993, p. 1).

Limitations in adaptive skill areas include communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work.

This means that students with IQ scores of 75 can be included in the mental retardation category if deficits in adaptive behavior are also present. It also means that a student with an IQ of 65 may not be classified as mentally retarded if there are no significant deficits in the areas of adaptive behavior. An IQ score alone, therefore, is not sufficient to classify a student as mentally retarded – other criteria are necessary.

By using the above criteria, four categories of mental retardation are now being used to place students in different educational programs. These categories are mild (educable, or EMR), moderate (trainable, or TMR), severe, and profound (S/P) retardation. The 1992 definition gives professionals adaptive skill areas that are well defined and IQ levels for determining a student's classification as mentally retarded. A change in trend occurred, however, with the AAMR recommending that professionals classify individuals with mental retardation according to levels of support needed to function as independently as possible. According to the AAMR, these levels begin minimally with intermittent assistance, progress to limited assistance, continue with extensive assistance, and finally end with pervasive assistance. These levels generally coincide with the more common labels of mild, moderate, severe, and profound retardation. Using this type of classification system takes the focus off the individual's limitations and places it on the educator's responsibility toward the student. It also reflects the ongoing trend in education to attempt to reduce stigmatizing labels (Biehler & Snowman, 1990).

Prevalence

The enactment of The Education for All Handicapped Children Act (Public Law 94-142) in 1975 gave schools the legal responsibility to provide free appropriate public education for all school aged children with disabilities. With this law came detailed record keeping responsibilities for educators and administrators in order to show compliance. The resulting data brought a surprising statistic to the forefront. A normal bell curve depicting IQ levels and prevalence rates should have shown approximately 2.27 percent of the overall population with an IQ of below 70. However, actual reported cases show that only 1 to 1.5 percent were being identified as mentally retarded (Hallahan & Kauffman, 1994).

Experts have cited at least three possible reasons for the discrepancy. First, the need to assess both

adaptive behavior and IQ may be partially responsible. Students must exhibit deficits in both areas to be identified as mentally retarded. Second, a reason for the discrepancy may be found in an overrepresentation of minority children in EMR programs (Robinson et al., 1989). Litigation regarding what is believed to be a mislabeling of minority students has somewhat reduced this number (Hallahan & Kauffman, 1994). Finally, because of the stigma attached to the label of mental retardation, some parents and educators have had a tendency to press for a diagnosis of learning disabled for higher functioning educably mentally retarded (EMR) students.

Causes and Identification of Mental Retardation

As discussed, the classification of mental retardation ranges from mild to profound levels. However, the mention of a mentally retarded child often brings to mind a typical Down syndrome child. This chromosomal abnormality which results in mental retardation causes the person to have very visible physical characteristics common to the condition. According to Hallahan and Kauffman as cited in Batshaw and Perret (1986) and Blackman (1984a)

> Persons with Down syndrome may have thick epicanthal folds in the corners of the eyes, making them appear to slant upward slightly. Other common characteristics include small stature, decreased muscle tone (hypotonia), hyperflexibility of the joints, speckling of the iris in the eye, a small oral cavity that can result in a protruding tongue, short and broad hands with a single palmer crease, and a wide gap between the first and second toes (pp. 125-126).

Concluding that the cause of all mental retardation is a single genetic abnormality and thinking that only persons with Down syndrome are mentally retarded would be as narrow as expecting all redheads to have a fiery temper. Though over 200 causes of mental retardation are known, it is impossible in most cases to determine a specific cause (Sutton, 1993).

Since most causes are unknown, it stands to reason that the majority of students with mental retardation do not physically look as if they have a disability. Often the disability becomes apparent only when the mentally retarded child begins to interact with his environment and the deficits in adaptive behavior are exhibited.

Adaptive Behavior

While intelligence quotients are based on standardized tests designed to assess a person's abilities as they relate primarily to academic performance, adaptive behavior is assessed through more subjective means. According to Hallahan and Kauffman (1994), the three most common measures of adaptive behavior are the Vineland Adaptive Behavior Scale, the AAMD Adaptive Behavior Scale–School Edition, and the Adaptive Behavior Inventory for Children. These measurements rely on the appraisal of a student made by someone who knows the student well, such as a parent, teacher, or other professional. The areas of assessment cover the same basic list of adaptive skills established in the AAMR definition of mental retardation.

There are some criticisms of these types of measurements, however. One of the main difficulties lies in the subjectivity of the assessor. Many of the questions may require judgments to be made by a person who sees the child in only one environment, such as a classroom. In addition, a child may perform similar skills differently in the classroom than he does at home. The conflicting information gathered creates a dilemma that can best be addressed by using a multidisciplinary approach in developing appropriate educational goals for the child (Robinson et al., 1989).

Educational Programs for Students with Mental Retardation

Educational programs for mentally retarded students have changed over the years. A major change is the increasing practice of inclusion. Inclusion is integrating students with disabilities into the regular classroom with non-disabled peers. This integrating is done regardless of the functioning levels of the disabled students. Present practices now include the teaching of academic subjects in the regular classroom. Past practices mainstreamed the students into nonacademic subjects such as art, music, and physical education. A special education teacher in a self-contained classroom taught academic subjects such as reading, math, and language arts.

Ways to integrate students into a regular classroom include peer tutoring and partial participation (Hallahan & Kauffman, 1994). Peer tutoring pairs the disabled child with the non-disabled peer for a certain project or subject matter. Student progress is supervised and monitored by the regular classroom teacher.

Partial participation is a concept that challenges the idea that severely disabled students cannot benefit from an activity just because they are not able to participate in the activity to the same degree as a non-disabled student. This approach allows the student to participate in the part of the activity that he is capable of performing, or the teacher modifies the activity so as to better include the disabled child.

The effectiveness of inclusion is still a subject of much debate. According to Markel and Greenbaum (1996) this philosophy "often conflicts with the need of some students with learning disabilities or ADD, for intensive one-on-one teaching by a professional trained in special education methodology. Too often, budgetary or political concerns preclude making these judgments on a case-by-case basis" (p. 132). Though these authors mention students with learning disabilities and ADD the same can be said for students with mental handicaps. Reif and Heimburge (1996), who support inclusion, also bring a balance to this philosophy by stating:

> Not every student is able to in a regular classroom, even with maximum amount of support from special education. The regular classroom setting is not the best or most appropriate placement for every student. Children with various handicapping conditions are entitled to appropriate placements and supports that will provide them with the most effective educational program to meet their needs (p. vi).

Another area of change is in the focus of curricular content. In the past, mildly handicapped students were given low level academic work and practice for the purpose of bringing the student up to a certain grade level. The more severely handicapped children were treated to a developmental model of education that focused on taking the student through normal stages of development regardless of his chronological age. The new emphasis, however, recognizes that education is preparation for life outside the classroom and designs the student's education plan accordingly. The adaptive skills outlined in the AAMR definition gives a good overview of how teachers should begin to think in terms of making each student's education valuable and appropriate. It must be remembered that "students who are retarded, no matter the severity level, need academic, self-help, community living, and vocational skills" (Hallahan & Kauffman, 1994, p. 139). It is no longer an issue of either academic or vocational training, but rather it is a matter of emphasis appropriate to the individual's needs.

Programs for Mildly Mentally Retarded

For elementary mildly mentally handicapped students, academics are stressed more than vocational training and are taught in a functional manner. Functional reading, math, and language are all taught so the child will be able to function more independently. Functional academics include recognizing signs throughout the community, using a telephone book, recognizing the value of money, making or estimating change, and writing short letters for expressing thanks, happiness, and other social exchanges. Each of these areas, so necessary to daily life, relies in some way or another on academic skills. Educational programs for mildly retarded students will address these skills and will stress their practical application to daily life.

For junior and senior high school aged mildly mentally handicapped students, applying academics to vocational situations should be the focus. Reading a newspaper, planning meals, following a recipe, shopping, and keeping accurate banking records all lead toward independent living. Being able to function as independently as possible is the educational goal for the teenage mildly handicapped student.

Programs for Severely Retarded

Students with more severe retardation will need levels of assistance that are more extensive and pervasive. That is, these students will need more frequent help and they will need it across all areas of their lives. Educational programs for these students should include several aspects. Curriculum and materials should be appropriate to the child's chronological age, rather than his mental age. The past practice of using "babyish" materials works against the goal of facilitating independence. It is also agreed that students should learn and practice skills in the environments where they will be used. This results in having curriculum that is functional and instruction that is community based.

Because mentally handicapped students do not easily generalize what they learn from one environment to another, classroom simulations are not enough. They need to get out into the community to put into practice the concepts that are being taught in the classroom. An additional benefit to community-based instruction is that it creates greater societal awareness of disabled students and their abilities.

This type of educational program would best use an integrated therapy model. Rather than having the speech, physical, or occupational therapists remove the student from the classroom to perform therapy, these support personnel would help the teachers and parents integrate the necessary therapy into all aspects of the student's daily life and routine. As one can imagine, family involvement is vitally important in designing and implementing the educational program. Vocational training and self-help skills are stressed more with severely retarded students than are functional academics.

Conclusion

I Corinthians 12:22 states, "Nay, much more those members of the body, which seem to be more feeble, are necessary." Regardless of the causes of mental retardation or the level at which a child is functioning, the fact remains that mentally retarded students need an education that will prepare them for life — a life that will bring honor to the Lord.

Armed with a proper background and perspective, Christian school administrators and teachers can design an educational program that will benefit the student and increase his ability to function more independently in everyday life and, more importantly, in the body of Christ.

Mentally handicapped Christians have a necessary function in the body of Christ. As Christian educators it is our responsibility to help them find that function and then to help them perform that function.

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