

MENTAL RETARDATION



DEFINITION:

Public schools use the following definition of mental retardation which is contained in the Rules for Implementing the Individuals with Disabilities Education Act (IDEA): “Mental retardation means significantly sub average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period that adversely affects a child’s educational performance.”

The American Association on Mental Retardation (AAMR) defines mental retardation as “substantial limitations in certain personal capacities. It is manifested as significantly sub average intellectual functioning, existing concurrently with related disabilities 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 begins before the age of 18.”

CAUSES:

The causes of mental retardation include, but are not limited to:

- Chromosomal abnormalities, such as Down syndrome and Fragile X syndrome
- Genetic metabolic disorders such as phenylketonuria (PKU) and Tay-Sachs disease
- Infections such as rubella and meningitis
- Poisoning from lead or drugs
- Traumatic head and brain injury
- Socioeconomic and environmental factors, including poverty

VARIOUS LEVELS OF COGNITIVE ABILITIES

- Mild MR
 IQ of 52-70
 Reach a level of education at least equal to the upper primary level.
 Develop mentally 1/2 to 3/4 the level of their “normal” peers.
 Acquire vocational skills at some level.
- Moderate MR
 IQ of 36-51
 Develop mentally 1/4 to 1/2 the level of “normal” children.
 Education at approximately a 2nd grade level is possible.

- Severely/Profoundly (S/P) MR
Grossly intellectually deficient.
Develop mentally at no more than 1/4 the level of “normal” children.
Learn some fundamental skills, but many never develop competence even in self-help skills.
Needs to be taught how to imitate and lacks the ability to attend to obvious stimuli independently.

POSSIBLE SIGNS, SYMPTOMS, AND CHARACTERISTICS:

- Obesity and overweight problems
- Congenital diseases
- Postural abnormalities: malalignment of the trunk or legs, protruding abdomen, flexed head, externally rotate the legs and use a wide base of support when walking and running
- Developmental patterns occur at a slower pace than other pupils
- Physical fitness and motor proficiency may be below normal
- Cardiorespiratory endurance may be a deficient performance area
- May be more successful in skills involving physical ability
- Function best in concrete, noncomplicated activities
- Generalization of skills may not occur without intervention
- Maintenance of skills may not occur without intervention
- Incidental learning may not occur
- Memory and attention span may be deficient
- Vocabulary may be limited
- These students may be underestimated
- May be easily frustrated
- May have an inadequate self image
- May lack motivation and aggressiveness
- Tend to be followers, not leaders
- May have difficulty exhibiting appropriate behavior
- May be easily upset with changes in routine
- May not be self-motivated
- May show little interest in play due to a lack of healthy play experiences

TEACHING TIPS AND SUGGESTED ACTIVITIES:

- Short instruction periods.
- Teach in small groups.
- Use few and simple words and maximize demonstrations.
- Over teach the cognitive information.
- Provide opportunities for choice of activities.
- Use peer partner.

- Emphasize range of motion exercises.
- Concentrate on postural righting activities.
- Concentrate on vestibular activities.
- Provide a well-rounded program of fitness and motor activities based on each student's present level of performance and developmental psychomotor needs.
- Allow for periods of rest during instruction.
- Simplify, demonstrate, positively reinforce, and use multisensory approaches.
- Plan activities with few rules to memorize.
- Program for generalization with the use of different people, equipment, environments, and times.
- Teach safety often by stressing cause-effect relationships.
- Provide prompt and consistent feedback.
- Check for skill retention often.
- Present information and instructions in small, sequential steps and review each step frequently.
- Generalize to community-based settings by teaching skills that the students can use frequently and apply to settings other than school.
- Offer activities that provide initial success.
- When appropriate, put in leadership roles.
- Systematically ignore inappropriate behaviors, model appropriate behaviors, and praise appropriate behaviors and responses.
- Program systematic, age-appropriate activities that include all domains of development including psychomotor, social, vocational, and academic objectives.
- Early intervention may lessen or prevent secondary problems such as posture and fitness deficiencies.

Information on this sheet contains only suggested guidelines. Each student must be considered individually, and in many cases, a physician's written consent should be obtained.