

35. CHILDREN WITH MENTAL RETARDATION/LEARNING DISABILITIES

(Alternative Terms: Mental Impairment, Mental handicap, mental subnormality)

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35.2 Introduction

35.2.1 Mental retardation/learning disability is a condition of arrested or incomplete development of mind. It is characterised by delayed development of skills, eg. language, thinking and movement and social skills. Adaptive behaviour is impaired, and the risk of exploitation is increased. Educational progress is limited. Mentally retarded children have an increased rate of other psychiatric disorders, and in particular, may show significant behavioural problems.

35.2.2 Mental retardation is divided into mild (IQ 50-69), moderate (IQ 35-49), severe (IQ 20-34), and profound (IQ less than 20).

35.3 Mild Mental Retardation

35.3.1 Most children with mild mental retardation acquire adequate speech for conversation and are able to care for themselves eventually, but their development will be delayed. Such children will require ordinary care which may need to continue for slightly longer than with normal children. Some special educational input is likely to be needed.

35.4 Moderate Mental Retardation

35.4.1 Children with moderate mental retardation are slower in developing; some will not achieve the ability to care for themselves. Unless associated with autism [See Chapter 37], or other psychiatric problems, such children would be able to communicate with others, and enjoy simple social activities. Care would be required for significantly longer than normal children, though the nature of the care would be much as for a normal younger child. There is an increased incidence of epilepsy in such children.

35.5 Severe Mental Retardation

35.5.1 Children with severe mental retardation have more limited development, with no prospect of eventually caring for themselves. There are often associated neurological problems affecting mobility. One third have epilepsy.

35.6 Profound Mental Retardation

35.6.1 Such children are severely limited in their communications; they may be immobile, or incontinent. They have no ability to care for their own basic needs, and require constant help and supervision. Two thirds have epilepsy: associated cerebral palsy and sensory impairment are common.

35.7 Care Needs

35.7.1 In children with mild mental retardation, the care needs of the child are unlikely to be significantly different from those of a normal child. At the severe end of the continuum, children will require constant attention for all their bodily needs, with no prospect of significant improvement. Between the two extremes, the extra care required for the child because of his or her mental retardation, will vary not only according to IQ, but also according to associated factors, eg. physical disorders, epilepsy, behaviour problems.

35.7.2 Generally, all children with moderate or greater degrees of mental retardation, are likely to have care needs significantly in excess of those for normal children for a period of their development; some of these children will improve, while others will fall further behind with time. Children who fall into the category of severe mental retardation will be heavily dependent on others for their daily care, and will remain so.

35.7.3 In addition to care needs, many moderately and severely retarded children will require extra stimulation to improve their development progress, as they are less able to seek and create varied and stimulating experiences for themselves.

35.8 Mobility Considerations

35.8.1 Mildly retarded children are not likely to have special mobility needs. As the degree of mental retardation increases the risk of associated physical disability also increases, and mobility needs may arise from these associated difficulties.

35.8.2 More severely retarded children are likely to place themselves at risk (from traffic, or strangers) if out alone, and may therefore need to be accompanied when out in order to be safe.

35.9 Further Evidence

- 35.9.1** If an IQ assessment has been undertaken by an educational, or clinical psychologist, this can be a useful guide, though often no full IQ assessment will have been made.
- 35.9.2** A report from a developmental paediatrician, paediatric neurologist, or psychiatrist specialising in mental retardation, may be helpful in establishing the degree of the problem.
- 35.9.3** A copy of the Statement of Educational Needs should prove helpful, and a report from the nursery, school, or special educational unit, should also provide useful information on care and mobility needs.

35.10 Down Syndrome

35.10.1 Introduction

- (i)** Down syndrome is the most easily recognisable cause of learning disability in children and consequently is discussed in detail here. It is a congenital condition, caused by the presence of an extra chromosome in addition to one of the normal pairs. In 8% of affected children the extra chromosome is attached to another chromosome (translocated), usually number 14 or 21. Occasionally children show milder forms when only some cells are affected (mosaic) or only part of the chromosome 21 exists in triplicate. The syndrome is usually recognisable at birth by very lax muscle tone (hypotonia) and a characteristic physical and facial appearance.
- (ii)** Intellectual impairment is always present, though the degree is variable. Learning difficulties range from quite mild to very severe, but are usually moderate/severe. Social and practical skills may be acquired which mask the severity of the problem. Simple literacy skills may be developed by some, but usually with limited comprehension. The limitation of reasoning ability is such that few are able to achieve full social independence, though most learn several self-care skills.
- (iii)** Behaviour problems may exist, in the form of overactivity, mischievousness and sometimes stubbornness. Other behaviour problems which are common in children and adolescents with Down syndrome include passivity, tantrums, disorders of continence eg soiling, and lack of inhibition which can put individuals at risk. Aggression and violence are rare. Psychiatric disorders such as depression and autism are commoner than in the general population.
- (iv)** Speech and language problems are a particular feature, due not only to intellectual factors, but to physical ones as well. The shape of the palate, small mouth cavity, relatively large tongue and tendency to nasal speech

lead to poor pronunciation of words. Recurrent ear infections, causing intermittent and variable hearing impairment, commonly add to the difficulties. The speech may be insufficiently clear to be understood by strangers.

- (v) Many systems or organs may be affected by congenital abnormalities. Heart malformation is present in about 40% of children with Down syndrome. This is variable in degree and effect, ranging from a small "hole in the heart" causing no problem other than the need for antibiotics to be given when dental procedures are undertaken, to complex disorders giving rise to heart failure and reduced life expectancy. Congenital abnormalities may occur in the digestive tract. Cataracts occur more often than in the general population, as do the common visual defects requiring spectacles to be worn.
- (vi) Children with Down syndrome are prone to frequent recurrent infections, particularly of the respiratory tract and middle ear. The latter often lead to accumulation of sticky fluid ("glue ear") which impairs hearing.

35.10.2 Developmental Progress

- (i) The child's development follows the normal pattern, but there is usually some delay in acquiring skills from the outset. At first the delay may not be obvious, especially if the child is actively and constantly encouraged to learn the skills which would come easily to a normal child. By about school age, however, progress has usually slowed. The overall rate is adversely affected by factors such as the presence of associated disorders, (see above), and it is not unusual for the acquisition of relatively simple skills to continue into adult life.
- (ii) Sitting, in children without associated disabilities, is usually achieved by about a year old, standing by 18-20 months, and walking by about two, though it may take considerably longer for full stability and co-ordination to develop.
- (iii) Communication skills are acquired particularly slowly. Single words often fail to appear until the age of about two, and simple sentences may be delayed to school age and beyond. In many cases real fluency is never achieved.
- (iv) Self-help skills are similarly delayed. Independent feeding is often not achieved by school age, and the progression from spoon to knife and fork may take some years. Toilet training is usually a long drawn out process, but a good half achieve it by school age. Personal hygiene may remain a problem eg menstrual hygiene, shaving. Children with Down Syndrome reach puberty earlier than children in the general population.
- (v) Understanding of relationships, both personal and in society at large, is limited. Emotional and social maturity are rarely achieved, and the risk of exploitation is high in adult life.

- (vi) Individuals with Down Syndrome tend to show the effects of ageing at a younger age than their peers. Onset of dementia of Alzheimer's disease type is common in the 40's and early 50's, with gradual loss of self-care skills.

35.10.3 Care Needs

- (i) Needs will depend on the stage of development, level of ability, and presence of associated disorders, as outlined above. There is a great deal of variability in this condition, and each case will require careful consideration.
- (ii) Care needs to infants without associated disabilities are usually little, if at all, greater than those of any child in early life, although sometimes the muscle tone is so poor that feeding may be a very prolonged process and, in exceptional cases, tube-feeding has to be employed.
- (iii) When developmental delay becomes more apparent, usually by about a year old, needs begin to increase. Skills such as self-feeding, communication and toileting fail to appear, creating the need for extra attention. Lack of understanding of such concepts as danger, cause and effect, and socially acceptable behaviour, coupled with a tendency to implicit trust, create the need for increased supervision.
- (iv) As education proceeds, skills are taught gradually, starting with dressing. This extends in the teenage years to choosing clothes, visiting shops, managing periods, shaving (at least with help) and preparation of easy meals eg beans on toast. Although a certain amount of independence may be attained eventually, this is usually only possible within a structured environment.
- (v) Night needs, in the absence of any associated disorder, should be little more than normal.

35.10.4 Mobility Considerations

- (i) Mobility needs arise in young children when walking is slower than usual to develop. Most affected children are able to walk by 5 years of age, but slow development is common if a child has repeated spells of immobilisation due to illness, and especially if there have been periods of hospitalisation. The presence of a severe cardiac, respiratory, or other disorder may, of itself, give rise to mobility needs.
- (ii) When physical mobility has been established, independence may eventually be achieved on simple well-known routes but not, usually, in unfamiliar surroundings.

35.10.5 Duration of Needs

Some needs existing in childhood decrease as self-care skills are learned. This is a slow process which often continues into adult life. Needs persisting beyond school leaving, however, are likely to remain.

35.10.6 Further Evidence

If additional evidence is needed, the most appropriate source will depend on what aspect of the case is under consideration. Information about associated disorders, periods of hospitalisation and other purely medical issues will be best obtained from the GP or hospital concerned. Questions about development, level of functioning, behaviour etc, would be better addressed to one of the professionals involved in community care. These may include a consultant paediatrician at a Child Development Centre, specialist health visitor, school staff, or social worker.