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MENTAL RETARDATION: AN UNRUSHED BANE TO OUR CHILDREN

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Abstract

The purpose of the study is to summarize the main research findings pertaining to mental retardation. This article focuses on the various aspects of mental retardation such as the criteria and basics through which we define mental retardation and its relationships with the present definitions given. This articles also gives a detail on the criteria of the classification according to the designated authorities. Prevention an important aspect of mental retardation is explained in detail in the aspect of etiology and treatment. The major focus of the article has been the role of nurse, which describes the perspective of the nurses in handling the clients with mental retardation.

Keywords: *Mental Retardation, Etiology, Prevention, Nurse*

INTRODUCTION

Mental retardation is a condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, i.e., cognitive, language, motor, and social abilities. Retardation can occur with or without any other mental or physical disorder. However, mentally retarded individuals can experience the full range of mental disorders, and the prevalence of other mental disorders is at least three to four times greater in this population than in the general population. In addition, mentally retarded individuals are at greater risk of exploitation and physical/sexual abuse. Adaptive behavior is always impaired, but in protected social environments where support is available this impairment may not be at all obvious in subjects with mild mental retardation.

DEFINITION OF MENTAL RETARDATION

There are may definitions given to describe mental retardation

Mental retardation refers to significantly sub average general intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior and manifested during the developmental period.

It is defined as a sub average general intelligence, manifesting during early developmental period. It is a state of developmental deficit, beginning in childhood, that results in significant limitation of intellect or cognition and poor adaptation to the demands of everyday life.

CLASSIFICATION OF MENTAL RETARDATION

ACCORDING TO DSM 5

In the DSM-5 the term 'mental retardation' was officially replaced by 'intellectual disability (intellectual developmental disorder)'. The term 'intellectual disability' is the equivalent of 'intellectual development disorders', which was adopted in the draft ICD-11.

The new terms of the DSM-5 refer to a disorder with its onset in childhood which includes intellectual and adaptive deficits in the areas of conceptualization, socialization, and practical skills. From now on, in order to make a diagnosis according to DSM, the following 3 criteria must be satisfied:

A. Deficit of intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning or learning from experience, and confirmed by both individual clinical assessment and standardized intelligence testing.

B. Deficits in adaptive functioning that failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

C. Onset of intellectual and adaptive deficits during the developmental period. The severity levels are defined based on adaptive functioning and not on Intelligence Quotient (IQ) scores because it was judged that both the adaptive functioning in the areas of conceptualization, socialization, and practical skills determine the level of support necessary to maintain an acceptable condition of life. In addition, when low (under 60), measures of IQ are no longer valid.

Therefore, we continue to distinguish four levels of severity (mild, moderate, severe, and very serious), but with different criteria from the DSM-IV and IV-TR.

ACCORDING TO ICD 10

A condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e., cognitive, language, motor, and social abilities. Retardation can occur with or without any other mental or physical condition.

F70-F79

Mental retardation

- F70 Mild mental retardation
- F71 Moderate mental retardation
- F72 Severe mental retardation
- F73 Profound mental retardation
- F78 Other mental retardation
- F79 Unspecified mental retardation

Mild Mental Retardation: It accounts for 80-90% of all cases, often develop like other normal children with very little deficit. It may progress up to 6th standard. They are referred as *educable*. Also, they can achieve vocational and social self-sufficiency with minimal support.

Moderate Mental Retardation: It accounts for 10% of all cases. These children can learn to speak. It may progress up to 2nd standard. They are referred as educable and trainable. They can perform semi-skilled or unskilled work under supervision

Severe Mental Retardation: It is often recognized in early life. There is significantly delayed developmental milestones may be present. They have markedly delayed speech and other communication skills. The basic training in personal health is necessary. They can perform simple task under supervision. They are referred as dependent.

Profound Mental Retardation: It accounts for 1-2% of all mentally retarded. It is markedly delayed achievement of developmental milestones. They need comprehensive nursing care or life support. This group is called as custodial mentally retarded.

PREVALENCE OF MENTAL RETARDATION

Mental retardation is seen in around 2 to 3 percent of the population. It very well may be characterized as mental capacity that is particularly less than ideal level and a diminished capacity to adjust to one's current circumstance. The beginning of the condition happens during the formative time frame, i.e., incubation through age 18 years. The prevalence of mental retardation in general population is 2-3% of children have an IQ below 70. The overwhelming majority 80% of mentally retarded fall into mild category and moderate is 12% and severe and profound is 7% and less than 1% respectively.

MENTAL RETARDATION ETIOLOGY

Various ecological, hereditary, or different elements can cause mental impediment. Sadly, in around 30 to 50 percent of cases, the etiology isn't recognized even after intensive symptomatic evaluation. Some people have an inborn mutation of the chromosomes; others had harm to the cerebrum at a basic period in pre-or post-pregnancy improvement. Obtained reasons for hindrance incorporate close suffocating, horrendous mind injury and focal sensory system harm.

Pre-birth reasons for mental retardation incorporate intrinsic diseases like cytomegalovirus, toxoplasmosis, herpes, syphilis, rubella, and human immunodeficiency infection; delayed maternal fever in the primary trimester; openness to anticonvulsants or liquor; and untreated maternal phenylketonuria (PKU). Entanglements of rashness, particularly in very low-birth-weight babies, or post pregnancy openness to lead can likewise cause mental retardation.

Metabolic problems are one more conceivable reason for mental hindrance. At times (e.g., PKU, hypothyroidism), hindrance is preventable with early treatment. Different problems (e.g., mucopolysaccharidosis, sphingolipidoses) are less receptive to early intercession. Sub-atomic medication has made it conceivable to analyze various circumstances alluded to as mitochondrial cell diseases.

Various single-quality problems bring about mental hindrance. A significant number of these are related with abnormal or dysmorphic actual qualities. Such circumstances incorporate neurofibromatosis, tuberous sclerosis, Noonan's disorder, and Cornelia de Lange's disorder.

Upwards of one fourth of people with mental retardation have a perceptible chromosome irregularity. Kids with Down disorder (trisomy 21) typically have profoundly conspicuous actual qualities, yet includes related with other chromosomal irregularities, like Klinefelter's condition (47, XXY), may not be as clear to relatives or the doctor. Different kids might have a little

cancellation or duplication of a specific chromosome that is seldom revealed; consequently, the aggregate is yet unsure. A few chromosomal irregularities are acquired from a parent however most happen all over again. Many recently portrayed clinical conditions have been found to have a related chromosomal irregularity (e.g., DiGeorge, Prader-Willi, Angelman and Williams disorders).

CLINICAL PRESENTATION

There are various signs and symptoms of mental retardation that can exist in youngsters and will fluctuate contingent on unambiguous attributes. These signs and side effects may initially become evident in earliest stages or now and again may not be recognizable until the youngster arrives at young. The absolute most normal side effects can include:

Learning and growing more slowly than different youngsters same age, turning over, sitting up, slithering, or strolling a lot later than formatively proper, Trouble imparting or associating with others, Below the norm scores on IQ tests, Hardships talking or talking late, having issues recollecting things, Powerlessness to interface activities with results, Trouble with critical thinking or coherent reasoning, Inconvenience learning in school. Failure to do regular assignments like getting dressed or utilizing the bathroom without assistance. For those kids with extreme scholarly incapacities, extra medical issues might exist including seizures, vision issues, hearing issues, and mental problems. Moreover, the accompanying classes are frequently used to portray each degree of scholarly handicap from gentle to significant. This will provide you with a more unambiguous thought of what this problem resembles on each level.

DIFFERENTIAL DIAGNOSIS

There are many differential diagnoses which can be considered with mental disorder, and we need to be careful about it. These include Deaf and Dump, Deprived children with inadequate social stimulation, Isolated speech defects, Psychiatric disorders, Systemic disorders, and Epilepsy

MANAGEMENT OF MENTAL RETARDATION

If diagnosed with intellectual disability, the child needs to undergo counseling therapy to cope with their disability. During the session, the therapist will interview the parents and observe the behavior of the child to know more about the condition. Ideally a child is regarded mentally retarded if he or she fails in both adaptive and IQ behaviors. Early intervention programs are available for infants and a family service plan is prepared that focuses attention to your child's needs. The plan consists of detailed information about the different services that your child will need to maintain a normal development. An Individualized Education Program (IEP) is arranged for, which will provide special education to the child and help them with their educational needs. Early intervention also includes occupational and speech therapy, training with special assistive devices, physical therapy, nutritional services, and medication.

ROLE OF NURSE

The role of nurse is very varied when it come to mental retardation. The role of the nurse includes. Assessment all children for signs of developmental delays. Administering prescribed medications for associated problems such as anticonvulsants for seizure disorders, and methylphenidate (Ritalin) for attention deficit hyperactivity disorder. Supporting the family at the time of initial diagnosis by actively listening to their feelings and concerns and assessing their composite

strengths. Facilitating the child's self-care abilities by encouraging the parents to enroll the child in an early stimulation program, establishing a self-feeding program, initiating independent toileting, and establishing an independent grooming program (all developmentally appropriate). Promoting optimal development by encouraging self-care goals and emphasize the universal needs of children, such as play, social interaction and parental limit setting. Promoting anticipatory guidance and problem solving by encouraging discussions regarding physical maturation and sexual behaviors. Assisting the family in planning for the child's future needs (e.g., Alternative to home care, especially as the parents near old age); refer them to community agencies. Providing child and family teaching. The role also includes Identification of normal developmental milestones and appropriate stimulating activities including play and socialization. Discussing the need for patience with the child's slow attainment of developmental milestones. Informing parents about stimulation, safety, and motivation. Supplying information regarding normal speech development and how to accentual nonverbal cues, such as facial expression and body language, to help cue speech development. Explaining the need for discipline that is simple, consistent, and appropriate to the children. Reviewing an adolescent's need for simple, practical sexual information that includes anatomy, physical development, and conception. Demonstrating ways to foster learning other than verbal explanation because the child is better able to deal with concrete objects than abstract concepts. Pointing out the importance of positive self-esteem, built by accomplishing small successes in motivating the child to accomplish other tasks. A nurse can also encourage the prevention of mental retardation, encourage early and regular prenatal care, provide support for high-risk infants, administer immunizations, especially rubella immunization, encourage genetic counselling when needed and teach injury prevention – both intentional and unintentional.

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