

INTRODUCTION TO MENTAL RETARDATION SYNDROMES AND TERMINOLOGY

This multidisciplinary book provides a rich amalgamation of the three authors' respective backgrounds in education, psychology and medicine. It is a most complete introduction to this complicated field, providing a very practical guide to terminology, syndromes, and selected references for further study. Students in special education, psychology, social service and nursing — as well as parents — will benefit from this full interpretation of a complex problem. Professionals in related areas will find it to be a usable reference book for interpreting reports and research related to mental retardation.

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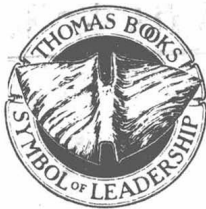
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TO OUR STUDENTS

FOREWORD

MOST professional people have a “conscience corner,” a place in their office where the unread books, magazines, and newsletters stack higher and higher. We cannot keep up with the millions of words that pile up, the new research and provocative thoughts, the efforts of those writers in our field who work so hard for a higher rank, more earnings, greater recognition, or just to satisfy their what-makes-Sammy-run syndrome.

Sometimes our professional friends cut through all the verbiage, and bring forth a product that must be pulled out of the “conscience corner.” It is our loss if we fail to do so.

This book is such a gift. It was prepared by three skilled educators whose rich backgrounds melt together in providing us with a practical guide to mental retardation — its terms, the types of problems involved, and selected references for further study. It is a tidy introduction for students, teachers, and parents.

Not often do a master teacher of mentally retarded children, a university professor whose background in the field cuts across psychology, evaluation, teaching children, and inspiring future teachers, and a pediatrician whose involvement has been intimate, sensitive, and scholarly, work together on any project, especially one that is so practical. Did I say, “Not often”? When has a trio like that *ever* cooperated to help the rest of us understand this increasingly complicated field?

This book is a successful effort toward a more complete interpretation of who these children are. As its authors say, it is “a place to start.” One might add, it is a fine beginning for students in this area of concern in so many of our families.

Willard Abraham

PREFACE

THE last few decades have witnessed accelerating accumulation of information and expertise with regard to understanding characteristics and origins of human defects. We have similarly made significant advances in medical, psychological, educational, and social management of handicapped individuals. And, almost each year we are encouraged by new insights and the development of new techniques that can enable us to prevent some forms of mental defect. Recent advances in the prevention potential of phenylketonuria, Rh-disease, rubella, and Tay-Sachs disease are compelling examples of our progress. Successful endeavors such as these have almost always been realized through multidisciplinary contribution.

Unfortunately, however, the lag is substantial between the acquisition of knowledge and the implementation of efforts to prevent mental retardation; or failing therein, to better manage that which has not been prevented. Complex reasons exist for this phenomenon which involve economics, tradition, and human value systems. Sometimes it merely takes time to educate the professionals who must do the job and to convince the public to pay the price. The need for increased cooperation and communication between disciplines is urgent if the gap is to be narrowed. It is very unlikely that any mentally retarded child, especially one with multiple handicaps, can ever approach his developmental potential, however modest that might be, without concerted cooperation and contribution of management skills from many different disciplines.

Our increasing awareness of the multidisciplinary needs of the retarded is reflected in university programs in education, psychology, sociology, genetics, medicine, nursing, and even law; often classes in these fields contain introductory informa-

tion about the nature of mental retardation.

Since each discipline brings its own unique terminology and approach to the study of mental retardation, it is not an easy matter for a beginning student, in education for example, to achieve a basic multidisciplinary comprehension of the subject. With this in mind, the authors, who have backgrounds in psychology, education, and medicine, have prepared a simplified, inexpensive reference book to help the beginning student in mental retardation clear terminological hurdles more easily.

This book is not intended to be an exhaustive compendium of all the knowledge available on the subject, but rather, a place to start. The first section of the book is introductory. The second section provides definitions of the most commonly used terms that might be encountered by beginning students. Words and terms have been defined as simply as possible and only as they apply to mental retardation. The third section lists the most commonly recognized mental retardation syndromes, their etiology, characteristics, and prognosis. The final reference section lists the sources for the information presented in the first three sections, as well as additional references that could assist students.

We sincerely hope that you will find this book helpful as you study and research the area of mental retardation.

Bryon C. Moore
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Clarence R. Laing

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B.C.M.
J.D.H.
C.R.L.

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**Introduction to
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PART I

INTRODUCTION

HISTORICALLY, a number of different labels have been applied to individuals that we now call mentally retarded. Such terms as *moron*, *imbecile*, *idiot*, *feeble-minded*, *mentally subnormal*, *mentally deficient*, and *mentally defective* have at one time or another been in popular use. And, there are scholars today who advocate replacing the term *mental retardation* with *general learning disabilities* (Dunn, 1973). The reasons why such terms come in and out of vogue are related to the ongoing search for descriptive precision and to the recurring need to escape from a term after it becomes stigmatized in the eyes of society, particularly parents and teachers.

In the past, the concept of mental retardation, by whatever label, has usually been defined in relationship to

1. significantly subnormal intelligence (as revealed by standardized, intelligence tests),
2. which either causes or exists concurrently with social incompetence (as revealed by measures of adaptive behavior),
3. with these impairments being manifested during the developmental years (age range from conception to adulthood),
4. of constitutional rather than psychological origin,
5. and essentially incurable.

Considerable controversy has always existed and will continue to exist with regard to the criteria of mental retardation. The evolution of definitions over the last seventy-five years is fascinating, and the serious beginning student might like to review discussions of the subject found in some of the more comprehensive introductory texts on mental retardation (e.g. Jordan, 1965; Kaufman and Payne, 1975; MacMillan, 1977; and Robinson, 1976).

The most recent definition to gain widespread acceptance is

that of the American Association of Mental Deficiency (AAMD) (Grossman, 1973). This definition includes criteria 1, 2, and 3 above, while omitting 4 and 5. The presence of concurrent intellectual and adaptive behavior deficits has been stressed in order to avoid labelling children *retarded* who do poorly on intelligence tests for reasons other than intellectual deficit.

Behaviorists tend to reject the concept of mental retardation (as caused by intellectual deficits) and suggest that *retarded* individuals are those whose history is composed of events which shape a limited repertory of behavior. (Bijou, 1966)

The concept of mental retardation is so broad that it frequently needs qualification in order to have practical meaning. For example, the same term may be applied to a child in an educable special education class as to a total care institutionalized bed patient. Obviously, children with such contrasting degrees of involvement would require differing programming consideration. Terms which imply degree of retardation such as *imbecile*, *idiot*, and *moron* have been used in the past in order to avoid such confusion. The term *moron* was even further divided into *high grade moron* and *low grade moron*. More recently, Rick Heber (1959) advocated subdivisions of *borderline*, *mild*, *moderate*, *severe*, and *profound*. Each of these subdivisions represented increasing standard deviations below the "average" range of intelligence. The *borderline* category included IQ test scores which fall in the one to two standard deviations below the mean. Later, in a 1973 revision of the AAMD classification system, Grossman dropped the *borderline* category setting the upper limit of retardation with the *mild* range (-2 to -3 SD).

Classifications of etiology have traditionally been dichotomized into *hereditary-environmental*, *endogenous-exogenous*, or some variation of the genetic-acquired differentiation. Terms such as *cultural defective*, *cultural-familial retardation*, or *garden variety defective* may have reflected early social concerns about mental retardation more than as diagnoses for research or treatment purpose. These dichotomies may have more theoretical than real significance since it is not yet possible to separate clearly the respective influences of genetic and environmental

factions. Furthermore, some conditions, such as hydrocephalus or microcephaly, may be either inherited or acquired.

More recently, groupings or categories such as *genetic defect*, *chromosome disorder*, *gestational disorder*, *infectious disease*, *postnatal trauma*, *metabolic disorder*, *brain disease*, and many others that have sprung into use reflect medical concern about treatment and prevention. The most systematic and widely used etiological classification system has been advocated by the AAMD (Heber, 1959; Grossman, 1973). Students involved in research related to etiology may find this system useful because it was devised with computer storage and retrieval of data in mind.

PART II

**TERMINOLOGY OF
MENTAL RETARDATION**

ABASIA — difficulty in ambulation.

ABASIA — ASTASIA — gait and stance difficulty on a psychiatric basis.

ABATEMENT — a reduction in the severity of a disease or condition.

ABDUCTION — motion directed away from midline of the body.

ABDUCTOR — a muscle that moves a limb away from the midline.

ABERRANT — deviating from the usual or normal.

ABERRATION — a deviation from the normal or usual. Genetic: irregularity in chromosome distribution during cell division.

ABILITY — competence, skill, or proficiency.

ABNORMAL — not normal; deviating from the usual or customary.

ABNORMALITY — a malformation or condition that deviates from the normal.

ABO INCOMPATIBILITY DISEASE — a hemolytic disorder caused by maternal antibodies crossing through the placenta and attacking the fetus.

ABORTICIDE — a substance or condition which destroys fetal life and results in abortion.

ABORTION — premature separation of the fetus from the uterus and mother, occurring as a result of either internal or external circumstances.

ABSORPTION — the process of taking substances through the skin directly.

ABSTRACT — conceived apart from any concrete or functional realities.

ABSTRACT REASONING — the ability to derive meaning from symbols.

ACCLIMATION — becoming adjusted to a new climate, environment, or situation.

ACCOMMODATION — the automatic ability of the eye to change focus at various distances.

ACENTRIC — not centrally located; especially used in reference to the positioning of centromeres within chromosomes.

ACADEMIC ACHIEVEMENT — scholastic level attained.

ACHIEVEMENT TEST — test of performance in a general area, i.e. reading achievement, arithmetic achievement.

ACHILLES TENDON — tendon attaching heel bone to calf muscles.

ACHLOROPSIA — color blindness for green tints.

ANCHONDROPLASIA — a hereditary type of dwarfism characterized by shortened arms and legs with a normal sized trunk, lordosis, and abnormalities of the craniofacial bone structures.

ACHROMATIC — defect in ability to discriminate colors; absence of color vision.

ACOUSTIC — pertaining to sound or the sense of hearing.

ACQUIRED — refers to conditions due to influences that were exogenous in origin; not hereditary.

ACROCENTRIC — type of chromosome in which the centromere is located near one end.

ACROCEPHALY — *see* syndrome section under CRANIOSTENOSIS.

ACROCEPHALOSYNDACTYLY — *see* syndrome section.

ACROMEGALY — hyperplasia (overgrowth) of skeletal extremities, principally of the fingers, toes, jaw, and nose due to overproduction of growth hormone in an individual with closed epiphyses.

ACROMICRIA — hypoplasia (undergrowth) of skeletal extremities; the opposite of acromegaly; another name for mongolism; Down's syndrome.

ACTINOGEN — radiation-producing material.

ACUITY — sharpness or clearness of the senses, especially hearing and vision.

ACUTE — sharp; when used with illnesses refers to sudden and severe phases of disease.