ABSTRACT
Human existence is characterized by challenges of various degrees. These challenges over the years have resulted to man not utilizing his full potentials. This paper examined one of these heinous human challenges – mental retardation. The paper investigated this condition starting from the concept, characteristics, classification and causes. Several ways to ameliorate the challenges of mentally retarded persons using psychological techniques were established.

Keywords: mental retardation, adaptive behaviours, behaviour modification, Psychological Interventions

INTRODUCTION
The concept of mental retardation has been subjected to several controversies ranging from the nature and causes of the condition and the proper term that would best describe it. Mental retardation is unique in the sense that it has some peculiar characteristics which could be considered to be negative. Many definitions abound for mental retardation. This is because different professions approach it from different viewpoints. For instance, doctors see it as something wrong with the brain or biological makeup of the individual and hence define it in that line. To educators, it is an increased inability or undue difficulty to learn or to do well in school. Social psychologists viewed it as a problem of social environment and therefore define it in terms of the individual’s inability to develop and maintain appropriate social and adaptive behaviours. The definition offered by Grossman (1973) cited in Ugwu (2015) is widely adopted by the American Association of Mental Deficiency (AAMD) and American Psychiatric Association (APA). According to the author, mental retardation refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behaviour and manifested during the developmental period. Nwankwo (2006) opined that Diagnostic and Statistical Manual of Mental Disorders, fifth edition anchors the definition of mental retardation and the basic criteria for its diagnosis on the standards set in 1973 by AAMD. This definition reveals that mental retardation is under-developmental ability which may be due to developmental problems before or after birth. It is pertinent to state that it is not a disease but only a condition describing various levels of intellectual, social and cognitive functioning which usually lie at the lower ends of the functional scale. It is not curable but can be controlled by education and training hence the need for this paper. The paper therefore investigated the problem and presents it under the following: characteristic, classification, causes and prevention of mental retardation. Also, how to educate the retarded persons and psychological interventions were treated extensively.
Characteristics of Mental Retardation

Signs of mental retardation can be revealed by closely looking at the definition offered by Grossman (1973) where attention should be focused in other to confirm that the condition is present. The areas include significant sub-average intellectual functioning, deficits in adaptive behaviour, developmental problems. These signs may therefore be observed under educational behaviour characteristics, social and adaptive behaviour characteristics, physique and physical characteristics, and clinical or medical conditions.

Educational Behavioural Characteristics

Mental retarded children learn very little or not at all on their own from objectives, events and activities in their environment in comparison with other children of their age. They may fail repeatedly and remain in the same class or programme without any noticeable improvement or learning. They seem incapable of making use of the earlier knowledge or experience in acquiring new knowledge, or in solving immediate problems. They cannot transfer knowledge from one situation to another. The cues and guiding principles to solve problems are not easily understood by mental retarded children. They have low language levels due to delayed language development; as a result expressing themselves intelligently becomes a problem. Their vocabulary and speech production is poor. They have difficulties in reporting or relating an experience in words. They have short attention span and could be distracted by other stimuli. Their interest may never be sustained long enough on a task for them to finish it. They experience much difficulty in learning anything and are very poor users of whatever knowledge that has been acquired.

Social Behavioural Characteristics

Mental retarded children are withdrawn in most cases. They do not relate with others but prefer to be involved in self stimulating activities. There is also a problem of interaction. They are not stable emotionally. For instance, a child who seems quite happy now may suddenly fall down and start screaming without any visible cause. He may also suddenly stop screaming and join others in a playground and start laughing as if he was not the person yelling a few moments ago. This is referred to as deficits in adaptive behaviour which make the child incompetent to handle the social and personal demands of his environment. They may sometimes display temper tantrums. This is show of unnecessary excessive anger with everybody, everything and even with themselves. They fight other children too often without any cause. They engage in destroying other children’s books, tear their dresses and bang their heads on the table or walls. Some mentally retarded children may develop a respectable level of good speech, but can use this only in a “cock tail syndrome” fashion (Obani, 1997). They tend to repeat everything said or heard in or out of sequence. When they learn a particular response, they produce it at every opportunity whether or not it is appropriate or called for.

Physique and Physical Characteristics

Onwuegbu (2003) listed eleven physical signs that mentally retarded children could be identified with. They are:

- The body parts are not equal. For instance, they have very short trunks, usually long hands or legs.
- They have very small head (microcephalus)
- They have very large head (macrocephalus)
- They have webbed toes and fingers.
- They have flattened nose
- They have flat feet
- They have a huge tongue
- They have very dry and scaly skin
- They have very scanty hair
- They have a tendency to excessive dental decay and very poor cod up-keep. Their voices could easily attract attention.
Clinical Features
The incidence of cerebral palsy and epilepsy are much higher among the mentally retarded than in the general population. The life span of severe mentally retarded individuals is known to be shorter than non-retarded individuals.

Classification of Mental Retardation
The older classifications of mental retardation used terms like Idiot, imbecile and moron. These were matched with IQs 0 – 29, 30 – 49 and 50 – 70 respectively. These classifications were not accepted and have been dropped because it was derogatory and stigmatizing rather than descriptive states of mental retardation. World Health Organization (WHO, 1974) suggested mild, sub-normality, moderate, sub-normality and severe sub-normality. Recent classifications of mental retardation tend to be based on the extent of intellectual disability as indicated by I.Q. scores. This classification is widely accepted and thus presented in a diagram below:

The Borderline Group
This classification as suggested by Rich Hebber is called the borderline. Members of this borderline group have IQ ranging from of 70 – 85. They have no striking deviations from the normal individual and therefore were considered inappropriate to be classified as mentally retarded. No physical, social and educational deviations. They have no difficulty with learning school subjects and can reach their aspirations in life if guided and motivated.

Mildly Mentally Retarded
This group constitutes the largest class of mentally retarded. They are similar to their normal peers as they exhibit no obvious physical or overt behavioural deviations. They differ only in their greater difficulty with learning school subjects. They have slower rate and lower degree of intellectual development. However they may excel in other areas such as sports and games, crafts and other physical – oriented activities. Nwankwo (2010) describe the mildly mentally retarded child as one who has the potentials for development in (a) minimal educability in the academic subjects of the school (b) social adjustment to
such a point that he can get along independently in the community (c) minimal occupational adequacy to such a degree that he can later support himself particular or totally at the adult level. Many members of this group do benefit from regular school programmes. Integration rather than segregation is favoured for this group.

**Moderately Mentally Retarded**
This group is more obviously handicapped than the mild group. They learn much less and show more of the physical and behavioural characteristics listed for the mentally retarded. They may adjust to the home environment but may not be able to adjust to the community. They may learn some routine tasks such as elementary hygiene; bathing, toileting, feeding and other but functional and economic independence is not possible. Onwueghu (2003) suggested that play materials such as sand and water in different corner of the classroom, clay for molding, toys and crayon is needed in training or teaching them.

**Severely Mentally Retarded**
This group functions at an intellectual level about one half of their chronological age as their IQ range is between 25 and 39. It is difficult for members of this group to adjust to life situations without help. They may never acquire the skills of reading and writing except probably at ages over twenty years.

**Profoundly Mentally Retarded**
Members of this group are grossly handicapped and the condition is so serious (physically and intellectually). For most of them, the ability to grow into adulthood is ruled out. They require life-long care in mental deficiency hospitals and homes. Their IQ is below 24 points.

**Causes of Mental Retardation**
Several factors have been identified as the cause of mental retardation. Inherited materials from one or both of the parents, infections or illness from the mother before or during pregnancy, malnutrition, the effect of drugs, birth trauma, accidents etc, may result in different degrees of mental retardation. For purpose of clarity, these causes will be examined under three broad dimensions.

**Pre-natal causes**
Bender (2005) identified six factors responsible for mental retardation. These factors include:

i. Drugs taking through self-medication during the first trimester period of pregnancy.
ii. Infections and Toxicants, German measles, syphilis and influenza.
iii. Chromosomal Aberrations, Irregular coding of genes.
iv. Rh Factor: Blood incompatibility
v. Hereditary Traits: Conditions that runs in families
vi. Metabolic Disorder: Inability of the system to metabolic glucose.


**Peri-natal causes**

i. Anoxia: Insufficient oxygen supply to the neonate or fetus due to prolonged labour.

ii. Improper use of forceps during difficult labour which eventually leads to the damage of the cranium.

iii. The use of sedative drugs to reduce labour pain.

**Post-natal causes**

Childhood diseases such as measles, whooping cough, polio, chicken pox, meningitis, jaundice and congenital syphilis, if not treated quickly and properly, may cause damage to the young brain and nervous tissues which may eventually lead to mental retardation. Poisonous materials and chemicals such as mercury and lead causes damage when taking in error. This damage may result to mental retardation.

**Prevention of Mental Retardation**
To prevent or reduce the incidence of mental retardation, Ugwu (2015) asserted that the following issues must be considered.

i. Genetic counseling: Intended couples should consult a doctor for medical advice before getting into marriage.
ii. Improved health care: Adequate medical care facilities should be provided for mothers and babies throughout the period of pregnancy and in the early period of growth and development of the baby.

iii. Rich and Balance Diets: Pregnant women should be taking balance diets and much fruits throughout the period of pregnancy. The newly born baby should be fed on rich and balanced diets.

iv. Age of Mothers: Very old mother and very young ones should be discourage from having babies.

**Educational Implication for Mentally Retarded**

To aid the mentally retarded attain some level of education, certain guidelines must be followed.

i. Concrete material should be used to make learning meaningful. This is because they do not understand abstract concepts.

ii. Teaching should be according to their mental age rather than their chronological age.

iii. They should be taught in part.

iv. Individual instruction should be used.

v. Repetition of concept in different ways is required.

vi. Learning should be short since they have very short attention span.

vii. Pupils in each class should be assigned according to the degree of the mental retardation.

viii. The class should not be crowded.

On the other hand, teachers are expected to provide training in socialization so that they can acquire some social skills. Teachers should equally organize field trips to places of interest. Work-study programme should be arranged for them in order to make them functional after school.

**Psychological Interventions**

There are two behaviour modification techniques that are useful in helping mentally retarded children gain some coping skills. The techniques as identified by Nwankwo (2006) are cognitive behaviour therapy and applied behaviour analysis.

**Cognitive Behaviour Therapy**

This method is used in teaching children with mild and moderate mental retardation some social and academic skills and tasks. The technique of self-instructional training is the most prominent in cognitive behaviour therapy. Self-instructional training teaches retarded children to act or guide their actions through speech. In the first instance, the teacher performs the task by giving instruction aloud to himself while the child watches keenly and listens. For example, the teacher may say to himself, “pick that pen on the floor” He really performs the action by picking the pen while the child watches. Later the teacher instructs the child to pick the pen on the floor. The action will be easy for the child to perform because the child has watched the teacher do it first. As the child repeat the action a number of time, he will master it and can handle such matters and related ones by himself (Nwankwo, 2006).

**Applied Behaviour Analysis**

In cases of severe and profound mental retardation, the victims may not be able to feed, toilet and put on their clothes and generally groom themselves. In these cases, the purpose will be to help them gain mastery over these self-care activities. To teach a severely retarded child any particular skill using applied behaviour analysis, the therapist has to analyze and divide the goal behaviour into smaller components or chains. According to Adima (1991) operant conditioning principle of reinforcement is usually applied to the child in every attempt made to achieve that component. For instance, the goal behaviour could be to teach the child how to eat with spoon. The therapist divides the behaviour into chains such as picking up spoon, scooping food from the plate into the spoon, bringing the loaded spoon to the mouth, removing food in it with lips, chewing and swallowing the food. There are two types of chaining – forward and backward chaining. In forward chaining, the therapist starts from the first component to the last like picking up spoon, scooping food from the plate into the spoon in that order. While in backward chaining,
the therapist starts from swallowing the food and then moves backward. Both forward and backward chaining have been effective in teaching needed skills to severe and profound retarded children.

CONCLUSION
Mental retardation is not a diseases but only a condition describing various levels of intellectual, social and cognitive functioning. It is not curable but can be controlled by education and training. When attention is given to the preventive measures listed above, the incidence can be reduced or eliminated.

REFERENCES