CHAPTER II

GENERAL DESCRIPTIONS OF THE OBJECTS OF THE STUDY

2.1.THE DESCRIPTION OF MENTAL RETARDATION CHILDREN

"Mental retardation", according to the American Association on Mental Deficiency, is " subaverage intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior" (Heber, cited in Liebert & Poulos, 1979).

Before a consideration of adaptive behavior was included in the definition, emphasis was placed solely on the intelligence tests score for classifying a person as mentally retarded. If an individual scored in the retarded range on an IQ test, he was classified as mentally retarded even if he functioned adequately in the community, at school, on the job, or with his peers. In other words, once a person scored in the retarded range it was highly probable that he would be considered retarded for the rest of his life. It is important to accent the fact that equal weight is now given to both the intellectual functioning and the adaptive behavior dimensions. In other words, to be classified as mentally retarded, a person must show deficits in both areas (Patton, 1983).

In the past, children were placed in special classes for the mentally retarded simply because they scored in the retarded range on standardized tests and had trouble with academic learning. Many of these have gotten along well in their community and with their peers. After leaving school, they have functioned successfully in their jobs, and in some cases have married and raised fine families.

According to American Association on Mental Deficiency definition, they really were not mentally retarded since they were functioning within the normal range in life situations and they were not deficient in adaptive behavior (Patton, 1983).

The most distinctive feature of mental retardation is inadequate intellectual functioning. Long before normal tests were developed to asses intelligence, the individual with mental retardation were identified by a lack of age-appropriate skills in learning and caring for themselves. Once intelligence tests were developed, numbers were assigned to indicate degrees of mental retardation (Santrock, 1998). With the current definition, those individuals who experience difficulty with school subjects and score low on tests, yet after completing school can get along well on a job in the community, may shed their classification on mental retardation (Patton, 1983).

There are some subcategories to classify mental retardation as shown below:

Table 2.1.1. Classification of mental retardation

SUBTYPE	IQ LEVEL
Mild	50-70
Moderate	35-49
Severe	20-34
Profound	Below 20

(Source: David G. Myers, Psychology, 1989)

2.2. MENTAL RETARDATION IN INDONESIA

According to Maramis (1994), it is estimated that 1-3% of the total number of Indonesian citizens suffer from mental retardation which is such a big amount. The attitude towards these retardaters reflects social attitudes of a certain culture or community. Mental retardation itself can be viewed as a medical, psychological, or educational problem, but based on a latest analysis it has become a social problem, because its prevention, cure and especially treatment and education of these retardaters can only be done well through social efforts. In Indonesia, many schools for children with mental retardation have been established, either by the government or by private foundations. Yet, the total treatment for this problem has not been existed.

2.3. CAUSES OF MENTAL RETARDATION IN INDONESIA

According to Santrock (1998), these etiological factors have been grouped into categories. Mental retardation can have an organic cause or it can be social and cultural in origin. Organic retardation is mental retardation caused by a genetic disorder or by brain damage; organic refers to the tissues or organs of the body, so there is some physical damage in organic retardation. Meanwhile, cultural-familial retardation is a mental deficit in which no evidence of organic brain damage can be found. Psychologists suspect that such mental deficits result from growing up in a below-average intellectual environment. As children, those who are familially retarded can be detected in schools, where they often fail, need tangible rewards (candy rather than praise), and are highly sensitive to what others – both peers and adults want from them. In the case of cultural-familial

retardation, some combination of heredity and environment is responsible for the low intellectual functioning. Psychosocial intervention (adoption, for example) can produce significant changes in intellectual functioning (Schwartz & Johnson, 1985). However, as adults, the familially retarded are usually invisible. It may also be that the familially retarded increase their intelligence as they move toward adulthood. According to Maramis in (1994), mental retardation can occur from genetic factors (genetical mental retardation) or unknown factors (simplex mental retardation). Both are entitled primary mental retardation. Secondary mental retardation may result from knowable external factors and they usually affect the brain during prenatal, natal or postnatal period.

The Guidance of Mental Disorder Diagnose Classification 1 *(Pedoman Penggolongan Diagnosa Gangguan Jiwa ke-1/PPDGJ-1*, cited in Maramis,1994*)* classifies clinical subcategories or situations at which mental retardation occur, as follows:

1. Infection and/or intoxication

   This category includes mental retardation resulting from brain damage because of intracranial infection, serum, medicines or any other toxic materials. Prenatal infections are only a small factor in the causation of mental retardation. Nevertheless, illnesses such as rubella (German measles), if contracted during the embryonic stage of pregnancy, can have profound effects on the developing child.

2. Birth injury

   Some children were born injured during the birth process. When mothers give birth, baby's head might accidentally be pressed which may

cause brain bleeding. Early brain damage may also result in a number of mental disorders that are sometimes found in the conjunction with mentally retarded intelligence. As a group, these disorders are known as celebral palsy.

3. Metabolism, growth and nutrient defects

Genetically transmitted defects in intelligence are almost always accompanied by mental retardation. These defects may take the form of an inability to metabolize certain food constituents. The best known of metabolic defect is phenylketonuria. The defect is an inability to metabolize the amino acid phenylalanin and the average IQ of untreated PKU children is 25, but treated children do much better.

4. Postnatal brain disease

This category includes mental retardation resulted from neoplasm and some reactions of brain cells in which its etiology has not been discovered yet. It is presumed that familial or heredity factors play important roles in causing mental retardation in this category.

5. Prenatal risks

The risks or diseases have been identified before the baby was born. Mental retardation can result from physical, chemical, or biological agents acting on the developing embryo or fetus. Because some of these agents may affect the developing child without overtly disturbing the mother or interfering with pregnancy, they are often difficult to identify with any precision. During the embryonic stage (the first two or three months), serious physical malformations may be caused by agents that have little or no effect later in pregnancy.

6. Chromosomal abnormalities

Down's Syndrome (mongolism) is one example of chromosomal abnormalities. The parents of Down's Syndrome children are usually genetically normal. The physical characteristics of Down's Syndrome children are recognized even in the newborn. The children have small heads and ears. Their heads have flat backs, their tongues are fissured, their eyes have a slight oriental cast. The children's hands are spadelike with short fingers.

7. Prematurity

Premature birth, because of maternal illness, poor health, or other factors, results in children with low birth weights. A percentage of these children will be mentally retarded. This category includes babies born with less than 2500 grams in weight and/or pregnancy period less than 38 weeks. Low birth weight is related to low IQ scores. As birth weight increases so does IQ up to a point. When birth weight exceeds 4000 grams, IQ scores begin to drop again. This drop reflects the adverse effects of factors associated with high birth weight such as maternal diabetes and some birth injuries.

8. Profound mental disorder

Mental retardation can also result from profound mental disorder during childhood. Children raised by wolves or locked in attics rarely develop normally, and their mental retardation is no surprise. Early psychosocial experiences may profoundly influence intellectual and even physical development.

9.Psychosocial deprivation

Mental retardation can result from biomedical or socio-cultural factors that are related to psychosocial deprivation and self-adjustment. To diagnose this defect, historical psychosocial deprivation is needed, usually caused by familial-cultural and/or social environmental deprivation.

2.4. THE LANGUAGE OF MENTALLY RETARDED CHILDREN

Mentally retarded individuals have deficits in their cognitive ability, therefore, they have also deficits in their language ability because cognition and language are two inseparatable parts. As stated in the previous chapter that the difference between normal and mentally retarded children is due to the duration of information process in the brain. Children with mental retardation are found to be slower information-processors. It means also that they are slower in acquiring language than normal children. They may started talking when they were babies, but they did not have good development or improvement in their language acquisition because of their deficits.

Since they are deficient in their cognitive thinking, they suffer from language difficulties. They acquire fewer vocabularies than normal children. They are only able to recognize or comprehend vocabularies that are commonly found in their daily activities. They will not be able or have difficulties to comprehend uncommon words or 'sophisticated' words because of the limited capacity of their long-term memory store. Their language acquisition in general is similar to the language acquisition of normal children. They tend to acquire 'easy' phonemes first and the difficult ones latter. 'Easy'

phonemes meant are phonemes which are considered acquireable for most people in Indonesia. Meanwhile, 'difficult' phonemes are those which are usually acquired latter than the 'easy' ones. 'Easy' phonemes for most people in Indonesia usually include /p/, /b/, /m/ and /a/. Difficult phonemes may include /k/, /g/ or /ʃ/.

Therefore, they may undergo various speaking experiences with their surroundings. Their parents, who commonly happen to be the closest persons for them, are assumed to have the least difficulty in understanding their speech, even though these mentally retarded children speak incorrectly or incompletely. These parents have been used to interpreting the altered speech to the closest actual meaning. Their peers, who have similar deficits, may also comprehend their speech quite well. During the observation, I found that these mentally retarded children are able to communicate well with their peers even though they have speech disorder. Their teachers at school can also interpret their speech well.

Problems may arise when individuals with mental retardation communicate with the society or strangers who are not used to dealing with them. Most people find it difficult to communicate with mentally retarded children. Many of these children speak incorrectly, incompletely and they often alter their speech. Society will find it difficult to grasp the actual meaning of the altered sounds and it will not be east to interpret their speech. It is possible that strangers or society will interpret the speech differently from the actual intended meaning.

2.5. TREATMENT AND EDUCATION TOWARD MENTALLY RETARDED CHILDREN

Regardless of the severity of the retardation, a retarded individual can be helped and can develop new skills. When mentally retarded individuals are properly trained and given carefully planned assistance, their potential for achieving, learning and living is enhanced (Patton, 1983).

A question that frequently arises regarding intellectual retardation is whether it constrains the development of appropriate social skills. There is a clear correlation between mental age and social competence. It has been argued that the relationship may not be a direct result of mental retardation. Perhaps, for example, it is not mental retardation itself but the failure to train retarded children in more advanced social skills that gives rise to the correlation.

Even among severely retarded children, careful and systematic use of modeling and reinforcement can be used to cultivate positive social skills and interactions. In one study, severely retarded children were trained in such tasks as passing a beanbag to another child or pulling another child cooperatively on a wagon. Before these experiences, the children had made no attempt to interact with others and simply played aimlessly by themselves; after training, the children began to observe the play of more advanced peers and in some cases initiated appropriate interactions themselves (Liebert & Poulos, 1979).

Behavior modification in institutions is usually aimed at helping the severely and profoundly mentally retarded learn the self-help skills necessary for everyday living. For example, the severely mentally retarded have been toilet trained through the use of carefully constructed behavior modification programs.

Because of its heterogenous nature, overall assessment of special educational are notoriously difficult to conduct. Nevertheless, factors in the special educational environment have been found to be particularly important in determining the success of an educational program. The first and most important factor determining the success is the student' initial ability. Second, classroom atmosphere has been found to exert an important influence over how well children learn. In other words, the success of a special education program is as much determined by the type of the students in the program and the teacher's style as it is by what educational approach the teacher follows.

2.6. GENERAL DESCRIPTIONS OF THE RESPONDENTS

In making a study on phonological alteration of Indonesian-speaking children with mental retardation, there are three respondents as the sources of data. First respondent, namely respondent A, is Dwi Marenza H. She is a female mentally retarded student with IQ level of 86. She is eleven years old in chronological age and classified into mild mental retardation. Second respondent, namely respondent B, is Andi Sasongko Kurniawan. He is a male mentally retarded student with IQ level of 65. He is nine years old in chronological age and classified into mild mental retardation. Third respondent, namely respondent C, is Achmad Ainur Rofiq. He is a male mentally retarded student with IQ level of 59. He is fourteen years old in chronological age and classified into mild mental retardation.

The more descriptive identity of each respondent is described below:

1. RESPONDENT A

- Name : Dwi Marenza H.
- Sex : Female
- IQ level : 86
- Age (in chronological age): 11 years old
- Classification of mental retardation: Mild
- Intelligence: - Ability to comprehend problems: almost adequate
  - Memorizing ability: almost adequate
  - Logic thinking: poor
  - Language ability: almost adequate
  - Motoric ability: poor
  - Numerical ability: poor
- Personality : - Extrovert
  - Requires extra attention
  - Egocentric
  - Over critical
  - Dependent
- Psychodynamic: Her limited cognitive ability requires constant training and adequate expectation to gain only limited learning achievements. This learning achievement is probable if the child is educated properly based on her conditions.

➢ Conclusion and suggestion:

- Requires independence training
- Requires development of self responsibility

-Requires medical stimulation

-Requires chances to be active in various situations and activities

-Requires a special school for mentally retarded children

2. RESPONDENT B

➢ Name : Andi Sasongko Kurniawan

➢ Sex : Male

➢ IQ level : 65

➢ Age (in chronological age): 9 years old

➢ Classification of mental retardation: Mild

➢ Personality :
- Extrovert
- Requires extra attention
- Dependent
- Labil
- Adequate self confidence

➢ Conclusion and suggestion: He requires constant independence training and requires a special school for mentally retarded student

3. RESPONDENT C

➢ Name : Achmad Ainur Rofiq

➢ Sex : Male

➢ IQ level : 59

➢ Age (in chronological age): 11 years old

- Classification of mental retardation: Mild
- Personality : - Static
  - Tend to be passive
  - Hesitates
  - Less self confidence
  - Labil
  - Can be influenced easily
- Conclusion and suggestion: His low IQ impedes his learning process and requires a special school for mentally retarded children.

CHAPTER III

PRESENTATION AND ANALYSIS OF THE DATA