MENTAL SUBNORMALITY

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The Year of the Child is a good opportunity to review some of the epidemiological aspects and problems facing the mentally retarded. These are people who mentally grow very slowly and thus remain to all intents and purposes children for most if not all their life.

Size of the Problem: The prevalence of subnormality is quite difficult to determine precisely. There are many reasons for this:

There are no sharp distinctions between the mentally retarded and the normal population. The distribution of I.Q. scores follows a normal (Gaussian) distribution curve:

Grading	% pop.	I.Q.	Mental
Genius.	0.13.	148+	23+
Very superior	2.13.	132-148.	21-23.
Superior.	13.6.	116-132.	18-21.
AVERAGE.	68.26.	84-116.	13-18.
Subnormal. (ESN)	13.6.	68-84.	11-13.
	2.13.	52-68.	8-11.
Severly subnormal	0.13.	52-	8-

I.Q. testing has a limited value in recognising subnormality. The procedure depends on the formulation, suitability, validity, and reliability of the test; the mood and motivation of both child and psychologist; and the child — psychologist relationship.

Bearing in mind that intelligence has been described as "the overall ability to perceive significantly; to remember selectively and anticipate eventualities and act appropriately" it is obvious that a thing so difficult to define is impossible to measure.

Furthermore, I.Q. scores do not tally with the person's ability to deal successfully with real life. Such variables as other physical defects, emotional and behavioral instability; family structure, education and financial position; and the facilities and opportunities available in the socio-economic climate of that part of the country have to be considered.

Many Subnormal children are easily detected especially if they have some marker physical abnormality eg Down's syndrome. But in the less severe type of subnormality in particular the educationally subnormal (ESN) the difference in performance from peers in early life is barely noticeable. However, as the normals grow at a faster rate mentally, they leave the subnormal child more and more behind, until the difference becomes obvious in the later years of school. Thus some cases are unfortunately detected as late as 9-10 years. On the other hand the severer the handicap the greater the tendency to die earlier due mostly to associated physical defects. Thus it is readily apparent that the prevalance of subnormality varies considerably with the age of the population considered.

It is also found that most educationally subnormals easily find their place in society, get a job and start a family. Thus the prevalance of subnormality drops precipitituosly with the school leaving age. It should never be forgotten that most subnormal children improve slowly with time — even their I.Q. scores tend to get higher.

None the less, many people would agree that the prevalence of subnormality in the general poulation is around 3%. At infancy the severly subnormals who can be detected number around 1%. By age 5 to 7 this drops to 0.4%. This age prevalence then becomes increasingly inflated by the less severely subnormal till a maximum is reached at age 10-16. After school-leaving age, for reasons explained above, this drops drastically to a level which remains quite stable thereafter with increasing age.

It is being increasingly recognised that in all cases early special training can make even the most severely handicapped more independent as regards feeding, clothing, and toilet. Most can be trained to be ambulant and with minimal behavioral and emotional problems. Understanding and speech can be developed to a practical level. The ultimate aim of attaining at least a partial measure of financial self-sufficiency is a goal within the reach of many such people.

Special considerations in Malta.

It is difficult to obtain statistics to assess the size of the mentally handicapped population in Malta. Some of the reasons for this have been discussed above. Still some measures need to be employed to avoid the presentation of a handicapped child at the lamentably late age of 16 to the authorities with the sole aim of obtaining the pension to which such a person is entitled to at this age! Precious little can be gained by

starting training at this age. Such cases are rare but not unheard of.

Most children present: 1) by the presence of a typical syndrome, or associated medical problem causing the mental handicap to be noticed early, by the paediatrician. 2) Parents may notice a delay in the development of milestones relative to their earlier sibs. 3) Teachers and family doctors will recognise more of those who present later.

By introducing the so-called 'at-risk register' where those expectant mothers with a history of previous children with mental handicap, or familial hereditary disease, or contact with rubella in early pregnancy, or those over 35 years old are entered, it is hoped that more early detection of at least some of these children may be made.

Teachers especially of the kindergarden classes need to be specially trained to be always on the look-out for such children. Also family doctors and paediatricians should not procrastinate decisions about the presence of subnormality in a child. It is known that the earlier that parents know that their child is subnormal, provided that sympathetic discussion of the individual problem is available, the quicker will they accept the situation and their child as he or she is. Otherwise a long period of confusion and disbelief follows with an added risk of refusal of the child. Many such parents may go from specialist to specalist (even abroad) hoping against hope that some miracle cure will be made. The facilities which exist to help them should be made known to them (—before they ask if any exist — a question which a surprising many do not put). One should not allow the parents to become shadows of their former selves, anxious and miserable and dependent on tranquilisers to keep them from going over the edge — a disturbingly common state of affairs. The early education of the parents to channel their love of the child into active and intelligent management of their child's development is essential. This helps overcome the parents' lingering guilt feelings, and dispell the sense of helplessness and incompetence in dealing with their own child. Among the problems that parents bring up frequently are the management of hyperactivity, sexual abuse and the question of their child's future, particularly of what will become of the child when they are dead.

Financial burdens are taken care of through pensions, free drugs, medical care, cheap food and transport to and from school. One should discourage both over-protection (— which may mean keeping the child indoors, hidden away from neighbours and visitors; and keeping the child on a regime meant for babies eg. diapers and bottle feeding for life. —) and from the tendency to push the child beyond his or her capabilities. At present organization of the management of these children involves the following system:

The child is refered to the MENTAL HEALTH CLINIC by parents, teachers, doctors, school psychologist, the at-risk register and the Combined Clinic (Pediatrician, Genetic counsellor and Obstetrician). From the MHC, the child is sent to a normal or special kindergarden and later to a normal or special trade school for preparation for open, home or sheltered employment.

Some problems have still to be overcome. A large problem includes the unavailability of staff like special child psychiatrists and genetic counsellors. Other staff are too few eg qualified teachers, social workers. Still others are as yet under training eg speech therapists, while others have to be brought from abroad eg play therapists. Another large problem is the as yet insufficient number of schools to deal with the increasing demand for entrance into such schools by the increasingly aware public The large waiting lists could cause placement of a child in an inappropriate school with detriment to the child and his or her classmates. Other needs include the as yet unavailability of formal I.Q. tests suitable for Maltese children.

It is to be increasingly expected that the traditional destiny of the mentally handicapped to finish up sooner or later in an institution will become slowly but surely a thing of the past.

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