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Degree of Parental Support and Level of Adaptive Skills of Children with Mental Retardation

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Abstract

This research article exposed significant relationship between degree of parental support and level of adaptive skills of mentally retarded children in functional skills, home living, community living, and social living activities. A null hypothesis no significant relationship between degree of parental support and level of adaptive skills was tested at .05 level of significance. The ten teachers and thirteen parents who comprised the population of respondents in selected Special Education (SPED) schools in Isabela, Philippines were involved. Jabay's instrument was adapted. It utilized Weighted Mean, Standard Deviation and Spearman Rho Correlation Coefficient. Parent's self-appraisal revealed "great" support with composite average weighted mean of 3.52. Teachers observed adaptive skills as moderately developed with composite average weighted mean of 3.20. Home living activities registered significant correlation to parental support with p-value of 0.016 and r-value of 0.702. Community living activities also registered significant correlation with p-value of 0.005 and r-value of 0.781.

Keywords: Parental Support, Adaptive Skills, Mental Retardation.

Introduction

An individual with mental disorder is a test and may cause tension to his/her family. Starting with the detection to habilitation or instruction, there is great effort families have to exert seeking for the reasons and diagnosis; with feelings of shame, disappointments and uncertainty of the future. American Association on Mental Retardation (ARMM) cited by Inciong et. al[1], described mental retardation or disorders as significant limitations in executing basic life skills which means that the person has difficulty in performing daily activities related to taking care of one's self, doing ordinary task at home and work related to the other adaptive skills areas. Areas may include academic work, if the child goes to school. The person possesses an extensively lower than the average intellectual functioning, which means that the person has significantly below average intelligence. The child finds it difficult to learn the skills in school that children of his age are able to learn. Intelligence Quotient (IQ) is approximately in lower IQ range 0 to 20 and upper IQ range of 70-75 based on result of assessment using one or more individual intelligence test. Mental Retardation exists along with associated limitations in two or more adaptive skills or behavior. This person fails to attain typical personal self-sufficiency and social responsibility expected of their chronological age and cultural group. Adaptive skills include the following: i. Communication (ability to understand and communicate information by speaking and writing through symbols, sign language and non-symbolic behavior like facial expression, touch or gestures) ii. Self-care (ability to take care of one's need in hygiene, grooming, dressing, eating, toileting) iii. Home living (ability to function in the home, housekeeping, clothing care, property maintenance, cooking, shopping, home safety, daily scheduling of work) iv. Community use (travel in the community, shopping, obtaining services) v. Social skills (initiating and terminating interactions, conversations, responding to social cues, recognizing feelings, regulating own behavior, assisting others, fostering friendship) vi. Self-direction (making choices, following schedules, completing required task, seeking assistance and resolving problems) vii. Health and safety (maintaining own help, identify and preventing illness, first aid, sexuality, physical fitness and basic safety) viii. Functional academics (learning the basic skills taught in school) ix. Leisure (recreational activities that are appropriate to the age of the person) and x. Work (employment, appropriate to one's age). Mental retardation manifests before age 18 to 22. This means that condition can start during pregnancy until the age of 18 to 22. A person who suffers from brain injury at age 23 or thereafter would not be considered mentally retarded, even if the other criteria are met because mental retardation is a developmental disability. Thus, an IQ score below 70 or 75 is not sufficient to classify a person as with mentally retarded. The person's adaptive behavior must also be impaired, and the condition must be originated during pregnancy until the age of 18 to 22.

The American Association on Mental Retardation (AAMR) which developed the widely accepted diagnostic classification system provides basis of the present study. AAMR defines Mental Retardation based on level of support needed or required by the children. The system focuses on capabilities and skills of retarded individuals rather than on their limitations. These levels

of support are classified as: i. intermittent, or "as needed", which are seen as short-term support, such as during as acute medical crisis; ii. limited, which are those supports needed regularly, but for a short period of time, such as employee assistance to remediate a job-related skill deficit; iii. extensive, support seen as ongoing and regular, such as long-term home living support; iv. pervasive, viewed as constant and potentially life-sustaining support, such as attendant care, skilled medical care, or help with taking medications. Those with moderate to severe degrees of mental retardation really need some kind of assistance in order for them to do certain task successfully[2].

Mental retardation varies in severity. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) is the diagnostic standard for mental healthcare professionals in the United States. The DSM-IV classifies four different degrees of mental retardation: mild, moderate, severe and profound. These categories are based on the functioning level of the individual. The American Association on Mental Retardation (AAMR) further cited that children with mild mental retardation are approximately 85% of mentally retarded population is in mildly retarded category with IQ score ranges from 50-75. They can acquire academics skills up to 6th grade level; can become fairly self-sufficient; in some cases live independently, with community and social support. Moderate mental retardation is about 10% of the mentally retarded population with IQ scores ranging from 35-55. They can carry out work and self-care tasks with moderate supervision; acquire communication skills in childhood; able to live and function successfully within the community in a supervised environment such as a group home. About 3-4% of mentally retarded population is severely retarded with IQ scores of 20-40. They may master very basic self-care skills and some communication skills; able to live in a group home. Only 1-2% of mentally retarded population is classified as profoundly retarded with IQ scores under 20-25. They may be able to develop basic self-care and communication skills with appropriate support and training. Their retardation is often caused by an accompanying neurological disorder. Profoundly retarded needs high level of structure and supervision[3].

Mental retardation has been known by many different names that are no longer used at present. The old labels are mentally defective, mentally deficient, feebleminded, moron, imbecile and idiot. According to Jabay Mental Retardation (MR) is not a disease. One will not catch mental retardation from anyone. Mental Retardation is not also a type of mental illness like depression. There is no cure for Mental Retardation. Nevertheless, most children with MR can learn to do many things. It just take them longer time and more effort than other children. Teachers may provide instructional processes in shorter and distributed (not massed) learning sessions, especially school living, community and environments. From an early age, life skills including daily living, personal/social skills, and occupational awareness and exploration should be taught. Along with vocational preparation and training for adult living, instruction in leisure and recreational opportunities and skills should also be a part of the educational program[4].

Heward cites five essential assumptions in using the AAMR definition: i. Existence of limitations in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the person's individualized needs for supports, ii. Valid assessments consider cultural and linguistic diversity, as well as differences in communication, sensory, motor, and behavioral factors, iii. Specific adaptive limitation often coexists with strengths in other adaptive skills or other personal capabilities, iv. The purpose of describing limitations often coexists with strengths, v. With appropriate supports over a sustained period, the life-functioning of the person with mental retardation will generally improve, vi. Parents of children with disability play a significant role in the child's education as full partners in the education process, vii. Parent of a child with disability plays an integral role in child's education process; and through parent-panel approach, parents, teachers and other professionals comply with spirit of Federal Law, and, more importantly, enhancing life of the child with special needs[5].

According to Drew, Logan and Hardman cited by Jabay[4], before a partnership between parents and teachers can be created, parents must value education and communicate importance of school to their children. When parents are supportive and involved in education, children tend to perform well in school. Parental involvement entails more than just sending children to school well fed and rested. Parents must ensure that their children arrive at school promptly, motivated with a positive attitude and prepared to work and learn[6]. Jabay[4], cited Beirne-Smith, Patton, and Ittenback on parental involvement as creating a positive learning environment at home and introducing activities supporting school learning. These parental responsibilities are met by: i. establishing a designated study space and personal system of organization, ii. limiting television viewing time, iii. reading aloud together and iv. providing opportunities to learn and practice self-control, social skills and responsibility[7].

Today, a new relationship is being forged between parents and professionals recognizing that working together can best results to success among handicapped children. The Philippine Special Education Handbook (1981) emphasized parents' involvement in the education of their children as responsibility. These could be enhanced through proper guidance of teachers in working with parents. Such service enables parents to: i. understand and accept their handicapped children; ii. appreciate objectively their child's limitations, needs and strengths; iii. understand the need for cooperative efforts in organizations like Parent-Teacher Association; iv. understand restrictions under which their child is operating; and v. seek out services of school, community, private persons, and organizations[8].

According to Jabay, parents can serve many functions to help their children develop their fullest potential. Parents as "teachers" means parents should be involved in teaching process. While a normal child picks up many skills on his own, a handicapped child needs special help. If parent is able to train his child at home, he is helping him function more effectively.

Parents as "adviser" means that parents should be involved in making educational decisions affecting handicapped children such as placement and programming usually were exclusive domain of professionals. Some parents are already regular members of decision-making groups and also function as advocate, which means parents should be leaders in making changes in educational system[4].

Concerned with improving quality and quantity of educational programs, parents should work for changes in administrative policies, laws, and court decisions affecting their children. Hence, this research endeavor was purposively selected to find out whether parental support and assistance and level of adaptive skills development of children with MR are positively related.

The following questions were considered: i. what is the degree of parental support given to students with mental retardation as assessed by parent respondents in terms of functional skills, home, community, and social living activities. ii. What is the level of adaptive skills development of students with mental retardation as assessed by teacher respondents in terms of functional skills, home, community and social living activities? iii. How significant is the relationship between degree of parental support and level of adaptive skills development of students with mental retardation?

Findings benefit the following: i. Children with Mental Retardation since all supports have given them aim to help them lead a normal and independent life in the future, ii. Parents will become more aware of appropriate ways of helping their children develop their fullest potential; iii. Teachers in a long term, will be benefited with the findings as changes or improvement among children with MR and their development of adaptive skills will lighten loads and responsibilities to them; iv. School Administrators will be helped in developing programs and activities that will enrich parents and teachers involvement and collaboration; v. Community will profit when children with mental retardation upon reaching full development of their adaptive skills will become assets instead liabilities to society.

Paradigm of the study includes the Degree of Parental Support Given to Children with Mental Retardation in terms of: i. Functional Skills, ii. Home Living Activities, iii. Community Living Activities, and iv. Social

Activities; and Level of Adaptive Skills of Children with Mental Retardation in terms of: i. Functional Skills, ii. Home Living Activities, iii. Community Living Activities, and iv. Social Activities.

Functional skills enable learner to acquire literary skills, take care of himself, pursue leisure and assume personal responsibilities and do some work. Home living activities include setting of the table, cleaning the home, cooking dinner, using toilet, dressing up and taking care of personal hygiene, operating home appliances, and participating in leisure activities. Community living activities involve using transportation, shopping and purchasing goods, interacting with community members, and using public building and settings. Social activities incorporate knowing rules of conversation, getting along in a group, playing a game, socializing within a family, making and keeping friends, and offering assistance to others.

Hypothesis; The null hypothesis there is no significant relationship between degree of parental support and level of adaptive skills of students with MR was tested at .05 level of significance.

Methodology

The study was correlational[9]. It involved ten teachers (ages 20-29) and thirteen parents (ages 30 – 39) that comprised the population of target respondents in selected SPED schools in Isabela, Philippines. Most parents were Bachelor Degree holders with monthly income of Php10, 000.00 and below.

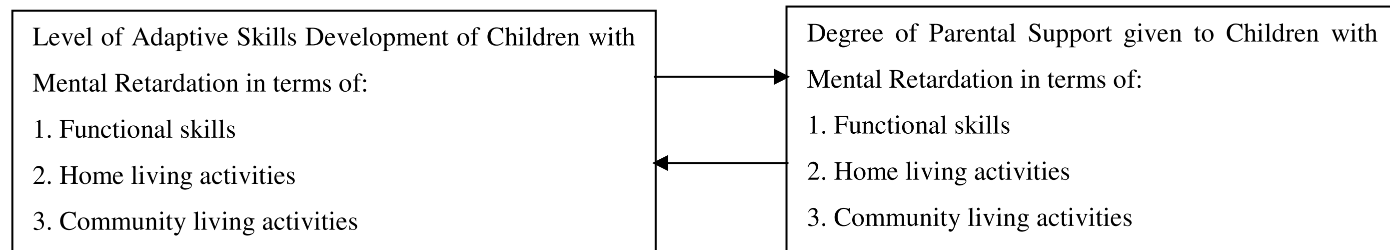

Figure-1
Degree of Parental Support

Generally, teacher respondents were married; finished only bachelor's degree; taught for less than five years and earned Php10,000.00. The study considered those students with mild to severe mental retardation such as Down syndrome, Autism Disorder with mild retardation, and those with other disabilities revealed as mentally retarded based on assessment obtained from their schools. Children with disabilities but are not mentally retarded were not included. Teachers assessed the level of adaptive skills of students while parents rated degree of parental support they gave their children.

This study adapted the research instrument of Jabay[4] in checklist format and contained two parts. The first part pertains to degree of parental support to: functional skills, home living activities, community living activities, and social activities; rated based on five-point scale: 5 – Maximum; 4 – Great; 3 – Moderate; 2 – Less; 1 – Minimum. The second part describes the level of adaptive skills of children with mental retardation. The same areas were also considered and rated in the level of adaptive skills as those of degree of parental support. The said instrument was subjected to face-validation by experts in the field of Special Education as to its suitability and functionality. It utilized Weighted Mean, Standard Deviation and Spearman Rho Correlation Coefficient.

Results and Discussion

Degree of Parental Support Given to Students with Mental Retardation: The composite average weighted mean of 3.52 based on self-appraisal of parent respondents revealed their "great" support to their children with mental retardation. However, results show that same respondents gave their highest average weighted mean of 3.68 interpreted as "great" on "Social Activities". This finding infers that parents strongly advocate social exposures and trainings given to children with mental retardation. Children with mental retardation also received "great" support on Functional Skills (AWM=3.66); and Community Living Activities (AWM=3.51). Only "moderate" parental support is given them in their Home Living Activities (3.21) (table-1).

Muñoz backed up said findings which concluded that children benefit significantly when adults take strong interest in their education[10]. Jabay[4] cited Lucido which disclosed parents of special learners' belief that their children made most gains in social skills: behaved more appropriately and took things with stride; lessen their feelings of boredom and frustration; and built up self-confidence so that they can interact with fellow regular students. Same study attested that mentally retarded children still have a possibility to acquire their fullest potential with the help of parents[11].

From the interview conducted, teachers claim that if given longer and ample time, mentally retarded children can learn adaptive skills. However, these skills may be forgotten if the child failed to come to school for a longer time and same skills are not practiced at home.

Level of Adaptive Skills of Children with Mental Retardation: Teachers observed that adaptive skills of mentally retarded children were moderately developed as gleaned from composite average weighted mean of 3.33. Data based from conducted interviews uncovered that nearly half of the teachers admitted that parent's over-protection and disappointments inverse student's dependence on them. Thus, impedes full development of child's potentialities (table-2).

Nuñez proved the need for more help to children with mental retardation on way to adulthood in different ways from what they needed during their early years. Preparations for simple occupations can be of great help for the more advanced. Social integration and exposure are potent vehicles for preparing mentally retarded children[12]. Results imply that efforts of parents and teachers of mentally retarded are not enough in building up their skills and potentialities.

Delos Reyes supported the outcome , which unveiled that children, though mentally retarded, are able to socialize; follow instructions; communicate with gesture; minimize tantrums; are enthusiastic with school work; minimize tendency to hit other people and build confidence especially when they are taught along with other students. The study proves that peer support is more effective than parental support in building the skills of children with mental retardation[13].

Table–1
Overall Assessments of Parents on the Degree of Parental Support to Children with Mental Retardation

Indicators	Parents			
	Average Weighted Mean	Standard Deviation	Verbal Interpretation	Rank
Functional Skills	3.66	.76	Great	2
Home Living Activities	3.21	.97	Moderate	4
Community Living Activities	3.51	.77	Great	3
Social Living Activities	3.68	.55	Great	1
Composite Average Weighted Mean	3.52	.64	Great	

Degree of Parental Support and Level of Adaptive Skills of Children with Mental Retardation: Spearman rho test was utilized to check if there are significant relationships between each of the parental support dimensions and level of adaptive skills of students. Result shows that among the pairings, it was the home living activities that registered a significant correlation to level of adaptive skills as indicated in the p-value of 0.016 and an r-value of 0.702. The r-value exposed a highly positive direction of relationship. This means that as level of adaptive skills increases (decreases), degree of home living activities given by parents also increases (decreases). The other pairings of parental support and adaptive skills did not incur significant degree of relationships (table-3).

Finding resembles the output of the study of Jabay, which divulged that degree of parental support on home living activities has a significant relationship on level of student's skills in home living activities[4]. Results imply that students with mental retardation can best learn skills in home living activities with fortified support given by parents. Parents are in best position to model these said skills at home since both child and parent are in the natural setting. Skills are easily learned and mastered when done in the natural environment. Learning of other adaptive skills may not be influenced much by parental support may be because of the nature of the skill to be learned. Skills in social activities is best acquired with peers; community living activities may be best obtained when the child is exposed outside home or school; and functional skills or academic skills are best enhanced in school setting.

Table-2
Overall Assessments of Teacher Respondents on the Level of Adaptive Skills of Children With Mental Retardation

Indicators	Teachers			
	Average Weighted Mean	Standard Deviation	Verbal Interpretation	Rank
Functional Skills	3.24	.88	Moderate	4
Home Living Activities	3.27	.44	Moderate	3
Community Living Activities	3.48	.73	Moderate	1
Social Activities	3.32	.71	Moderate	2
Composite Average Weighted Mean	3.33	.55	Moderate	

Table-3
Relationship of each Parental Support Area and Adaptive Skills of Children with Mental Retardation

		Functional Skills (Parents)	Home Living Activities (Parents)	Community Living Activities (Parents)	Social Activities (Parents)	Parental Support
Adaptive Skills	Correlation Coefficient	.145	.702*	.337	. 396	.455
	Sig. (2-tailed)	.670	.016	.311	.228	.160

Tested at .05 level of significance

Table-4
Relationship of Parental Support and Adaptive Skills of Children with Mental Retardation

		Functional Skills (Teachers)	Home Living Activities (Teachers)	Community Living Activities (Teachers)	Social Activities (Teachers)	Adaptive Skills
Parental Support	Correlation Coefficient	.114	.682*	.781**	.600	.455
	Sig. (2-tailed)	.739	.021	.005	.051	.160

*Correlation is significant at the 0.05 level (2- tailed).

Findings show that amid pairings, still adaptive skills in home living activities recorded a significant correlation to degree of parental support, proven by p-value of 0.021 and an r-value of 0.682, which conveys a positive direction of relationship. Finding indicates that as parental support is intensified, level of students' skills in home living activities is also enhanced. Adaptive skills in community living activities also registered a significant correlation to degree of parental support with its p-value of 0.005 and an r-value of 0.781, which discloses a strong relationship. This signifies that students' skills in community living activities are strengthened by enhanced parental support. Other pairings in different areas of adaptive skills did not obtain significant relationship with degree of parental support (table-4).

Interviews were conducted to further investigate nature of the relationship. Teacher respondents were asked to share some of factors affecting adaptive skills development of children with mental retardation. Teachers claim that level of mental retardation of children is a very important factor that affects ability of the child to develop his/her adaptive skills. They observe that children with significant sub-average I.Q are hard up in picking-up simple lessons and instructions. This concludes that children may have received a high degree of support but some of their level of adaptive skills areas may not be high because of the level of mental retardation they possess.

During the conducted observations and immersions, researchers noted some remarkable characteristics and observed behavioral tendencies of mentally retarded children: i. display very challenging behaviors most of the time; ii. some are extremely silent during the conduct of lessons; iii. give no reactions or blank stares and facial expression when stimulations are given; iv. hard-up socializing with others even with teacher; and v. could hardly run for errand even just for very simple tasks.

The study of Jabay unfolded same results that degree of parental support in home living activities is strongly correlated to level of adaptive skills[4]. The present study did not show any correlation between parental support in social living activities and level of adaptive skills of students with mental retardation, but the above-mentioned study uncovered strong correlation in said pairing. Same study revealed no correlation between parental support in community living activities with p-value of .130 and level of adaptive skills with an r-value of .093, while the present study exposed a significant relationship as shown in the p-value and r-value, respectively.

Outputs imply that children may learn some of their adaptive skills not merely from the support of parents but more on the hands on activities and exposures offered in SPED schools. As children with mental retardation stay longer in the SPED institutions, they tend to learn other adaptive skills through independent learning activities, gadgets, natural classroom situations/settings which are provided during the teaching-learning process.

There are other correlations studies conducted internationally that may give enlightenment to the present study. The study of G. Tirumala Vasu Deva Rao investigated significant relationship between attitudes of high school students toward value oriented education with other variables. Results of said study show that when grouped according to sex, locality, class, type of school management and other various combinations, high school students have positive attitude towards value oriented education and all pairings noted no significant difference in this attitude[14].

G. Thirumala Vasu Deva Rao also examined the relationship between mental health and gender, management and work experience of high school teachers. Findings uncovered no significant difference in mental health among high school teachers when grouped according to gender, management and work experiences[15].

Conclusion

Parent respondents revealed their "great" support to their children with mental retardation. Teacher respondents observed that adaptive skills of children with mental retardation were moderately developed. Degree of parental support is correlated with level of adaptive skills in home living activities and community living activities and it has no bearing with level of adaptive skills in functional skills/academic skills and social living activities. Only parental support in home living activities has a significant relationship with level of adaptive skills of children with mental retardation. Parental support in functional/academic skills, community living activities and social activities are not correlated with level of adaptive skills.

The following are recommended: Parents of children with mental retardation must intensify giving their support to their children in terms of functional skills development, home living activities, and community living activities. Follow up at home is also very much needed for these skills and activities to become routine in their daily lives. Parental support may not have a strong impact in skills development, but these may strengthen children's willingness and determination to develop their potentials to the full.

There must be a close coordination between parents and teachers in providing adequate support to students to maximize the development of their adaptive skills. It may be wiser to consult and work closely with other service-providers (medical/clinical specialists and therapists) for referrals as regards special child's present level of performance and possible remedies for his/her skills permanence and enhancements. Intensify parent education and training on how they can be of real help as to the type of support they give to children; how to categorize the type of help and degree of adjustment or independence needed; and the adoption of school program for them to determine discrepancies in physical, social, emotional, intellectual and academic growth.

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