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# Patterns of intellectual, adaptive and behavioral functioning in individuals with mild mental retardation

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### ABSTRACT

Many researchers have studied the population of individuals with mild mental retardation (MIMR) as if it is a clear entity. Few researchers have investigated potential subtypes within the MIMR population. The purpose of the present study was to investigate which subtypes can be identified on the basis of intellectual, adaptive and behavioral functioning. Seventy-three individuals with MIMR were assessed on measures of intellectual, adaptive and behavioral functioning. An agglomerative hierarchical cluster-analytic technique was used to define potential subgroups with characteristic behavioral patterns. Four subtypes were identified. The behavioral patterns are described and implications for assessment are discussed.

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## 1. Introduction

A person's intelligent quotient (IQ) score plays an important role in determining the level of support for individuals with mental retardation (MR). The IQ criterion, however, is too limited to determine the support they really need, in particular with regard to individuals with mild mental retardation (MIMR) (IQ between 50–55 and 70). The reliance on only the IQ criterion to determine the appropriate level of support masks the true nature of their needs, with major consequences for their quality of life. These individuals usually not only have problems in finding the right type of education

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(Bouck, 2004) or work (Bouras & Drummond, 1992; Richardson, Koller, & Katz, 1988) but are also often left without appropriate support (Fuijara, 2003; MacMillan, Gresham, & Siperstein, 1993; MacMillan, Siperstein, & Gresham, 1996; Maughan, Collishaw, & Pickles, 1999; Rutter, Tizard, & Whitmore, 1970). Therefore, the validity of MIMR, based on a single IQ criterion, can be seriously questioned (MacMillan et al., 1996). In the latest definition of MR, the American Association on Intellectual and Developmental Disabilities (AAIDD) emphasized that more criteria in addition to IQ are important and necessary. MR was redefined as a multidimensional construct based on the dimensions of intellectual abilities, adaptive behavior, participation, interactions and social roles, health and context (Luckasson et al., 2002). In the current study three dimensions are explored: intellectual abilities, adaptive behavior and health in terms of behavioral functioning and DSM-IV classifications.

### 1.1. *The intellectual perspective*

Children with MIMR are often characterized as having problems with abstract thinking and problem solving. Research has been conducted to gain insight into the academic learning problems of these children (Fletcher, Scott, Deuel, & Jean-Francois, 1999; Gresham, MacMillan, & Bocian, 1996; Jones, 1996), e.g. the underlying aspects of their cognitive functioning such as difficulties in selective attention (Bergen & Mosley, 1994; Merrill, Cha, & Moore, 1994; Merrill & O'Dekirk, 1994), working memory (Van der Molen, Luit, & Jongmans, 2007) and use of strategy in learning (Bray, Fletcher, & Turner, 1997; Fletcher & Bray, 1995; Wolman, Van den Broeck, & Lorch, 1997). The cognitive profiles of the individuals showed so much variability that it was impossible to define a valid group profile (Baumeister, 1997; Fletcher, Huffman, Grupe, & Bray, 1998). However, Fletcher, Blair, Scott, and Bolger (2004) recently found different patterns of cognitive abilities suggesting strengths and weaknesses in the cognition of different groups of children with MIMR.

### 1.2. *The adaptive perspective*

MIMR can also be defined in terms of adaptive functioning. The level of functioning corresponds to a developmental age of approximately between 6–7 and 11 years (Došen, 2005a, 2005c; Kraijer & Plas, 2006). More specifically, adaptive behavior is defined as “the performance of the daily activities required for personal and social sufficiency” (Doll, 1953; Sparrow, Balla, & Cicchetti, 1984). It can vary during the course of one's life and is not a permanent state of being (Luckasson et al., 1992). Individuals with MIMR need support in the areas of community activities, self-care, home living and work (Fuijara, 2003). These problems are a result of the social aspects involved in these areas of functioning (Embregts, 2000, 2002; Guralnick, 1990, 1999; Guralnick, Connor, Hammond, Gottman, & Kinnish, 1996; Leffert & Siperstein, 2002; Masi & Marchesi, 1998; Nabuzoka, 2000).

### 1.3. *The behavioral perspective*

The prevalence rate of severe problem behavior is at least three times higher in children and adolescents with MIMR than in the normal population (for a review see Wallander, Dekker, & Koot, 2003). Following the dimensional approach, researchers have demonstrated that these individuals display more aggressive, delinquent, depressive and anxious behavior than individuals without MIMR. Using a categorical approach they have shown that many DSM-IV disorders occur in children with MIMR; multiple disorders are present in as many as 36.8% of the individuals who meet DSM-IV symptom criteria. This co-morbidity is also associated with a high risk of pervasive limitations in adaptive functioning (Dekker, Koot, van der Ende, & Verhulst, 2002). In young adulthood, the prevalence of behavioral problems has been reported to increase (Emerson et al., 2001; Joyce, Ditchfield, & Harris, 2001).

The findings of the above-mentioned studies demonstrate that there is considerable variation in intellectual, adaptive and behavioral functioning among individuals with MIMR. The aim of the present study was to investigate which subtypes can be identified in the heterogeneous population of individuals with MIMR based on level of intellectual, adaptive and behavioral functioning.

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