SLOW LEARNERS AND MENTAL HEALTH PROBLEMS:
OVER-REPRESENTED AND OVERLOOKED

By Steven R. Shaw, PhD, NCSP
Greenville (SC) Hospital System

Children with low intelligence, also known as slow learners, often suffer extreme pressures in the classroom. This population is loosely defined as children with intelligence test scores between 70 and 85 (below average) and comprises approximately 14% of the school population. Slow learners are rarely eligible for special education programs, yet frequently do not have the skills to be successful in school. The resulting stress may create emotional and behavioral problems. Counseling and other mental health services often ignore or do not adequately address the needs of children with low intelligence who often do not have effective coping or social skills.

Background

The number of children with low intelligence is greater than all children with learning disabilities, mental retardation, emotional disturbance, and autism combined. Children with low intelligence display a disproportionate number of problems associated with school failure, such as school dropout, functional illiteracy, and low group test scores.

Slow learners have a greater proportion of problems such as becoming unwed parents, illicit drug use, unemployment, underemployment, and alcohol abuse. Slow learners are over-represented in prison populations, are more likely to become violent offenders, and are more likely to become members of gangs and hate groups. Slow learners are also more likely to have anxiety disorders and mood disorders.

In other words, children with low intelligence are destined to become disproportionately represented in major educational, societal, and emotional problems. Mental health, behavior supports, and prevention resources are scarce and getting harder to find every year. There seem to be few large-scale innovative educational or mental health programs for children with low intelligence.

Stressed and Ignored

The fields of education, psychology, and medicine continue to make strides in the knowledge of complex developmental disorders in children. Over the last 30 years, research and innovative clinical practice have improved the ability to assess and intervene for children with such complex disorders such as Attention Deficit Hyperactivity Disorder, autism and other pervasive developmental disorders, and learning disabilities. Treatments and funding for mental health and behavior management programs have improved tremendously. Children with these disorders are far better off than they were 30 years ago.

Systemic factors. Unfortunately, children with low intelligence are caught in a squeeze. Not only are there few remedial or support services available, children with low intelligence are being pressured by current education mandates for accountability and high stakes testing. With many states requiring a specific level of performance on group achievement testing in order to be promoted to the next grade or graduate from high school, children with low intelligence may not be able to navigate these additional systemic hurdles. Without supportive programs or a responsive general education system, the large percentage of children with low intelligence who drop out of school is likely to increase. Failure to earn a high school diploma is a major factor in future poverty, unemployment, and mental health problems.

Low skills lead to mental health problems. A commonly noted pattern is that children are assessed for special education, found to be children with low intelligence, and determined not eligible for special education services because they are neither so low as to meet criteria as mentally retarded nor of high enough ability to meet criteria as learning disabled Yet, because these children do not have the academic skills to succeed in the general classroom, they experience repeated academic failure. Many are referred a few years later for emotional and behavior problems because failure to provide adequate early educational interventions might lead to increased frustration, and feelings of hopelessness. Although there may be alternative explanations, there are consistent observations that children
diagnosed as having low intelligence may experience future behavior problems.

Academic Motivation and Mental Health

Policy issues. Policies of increased retention and the reliance on high stakes standardized tests often serve as barriers to developing academic motivation in these children. Non-graded classrooms, social skills training infused into nearly all aspects of curricula, elimination of grade retention, and instruction that involves the basics of direct instruction of material, strategy instruction, scaffolding, and systemic review can all lead to success. Successful children are likely to become academically motivated children. Academically motivated children are inoculated against the real risk factors of low intelligence, low academic achievement, and challenging home environments. Increasing barriers by escalating grade-retention rates and requiring a minimum score on a test can reduce academic motivations and increase feelings of academic hopelessness.

Impact of failure. Lack of academic motivation is best viewed as the first step in a downward spiral of low self-esteem, helplessness, hopelessness, and depressive symptoms. School psychologists and educators have the power to interrupt some aspects of this downward spiral. Experiencing repeated failure is a primary feature in the development of poor motivation. In other words, when there is no reinforcement to support strong academic work habits, development of life goals, and the ability to visualize a successful future, academic motivation cannot develop.

Issues in Mental Health Diagnosis and Skill Development

Diagnostic overshadowing. In the mental health literature on children with mental retardation there is a process called diagnostic overshadowing. This means that professionals tend to attribute all behavioral, social, and emotional problems to mental retardation in children diagnosed with mental retardation. Alternative explanations and psychiatric diagnoses are often not considered when working with a child with mental retardation. For children with low intelligence, there may be the reverse case of diagnostic overshadowing. That is, professionals ignore the real-world influences of low intelligence, such as poor coping skills, poor social skills, repeated failure experiences, and the risk factors associated with poverty, and attribute all behavioral, social, and emotional problems to the psychiatric diagnoses.

Impact of limited coping skills. Children with low intelligence have simple and concrete coping skills that are available to manage a complex and abstract world. These limited coping skills frequently are not sufficient to address complex social interactions, understand basic social rules, understand ambiguous situations, regulate emotions, initiate behaviors, plan, or to organize life events. The result is that children with low intelligence often withdraw, appear anxious or depressed, are inattentive, and respond impulsively or aggressively owing to their limited effective coping skills. For example, children with low intelligence often are accused of lying. In most cases, the purpose for lying is not oppositional. Lying is a form of denial, a primitive defense mechanism. Aggressive responses are usually due to errors in interpreting ambiguous social interactions as threats, then responding belligerently in perceived self-defense or a form of vengeance against a perceived slight. These children require direct training and guided practice to develop and apply more sophisticated coping skills and supervised practice in reading social situations.

Prevention

The cycle of school failure, frustration, withdrawal, lack of motivation, and hopelessness can be disrupted by simple teacher actions. There are classroom activities that are effective in reducing problem behaviors and increasing self-esteem.

Spend time with slow learners. Skill development is critical, but so is a sense of belonging. Children with low intelligence often feel that teachers do not want to spend time with them, that they have no friends, and generally feel alienated from the school experience. Teachers often report that these children are not reinforcing to them, are often the most challenging behavior problems, and that they spend less time with these children than with children of average to above average intelligence.

For example, the teacher can make a list of the five children in the class with whom he or she least likes to spend time. The teacher does not need to share this list with anyone. This list usually consists of children who are withdrawn, with discipline problems, with attention problems, and with learning problems. The majority of children on this list will be children with low intelligence. Then, the teacher should dedicate 3 minutes per week to spending time with each child on the list. This time should be spent not teaching but rather in engaging in small talk, such as discussing family pets, hobbies, clothes, or maybe playing checkers. These 3 minutes are not contingent on any behaviors. What teachers find is that the child is more motivated to please the teacher, feels less alienated, and has fewer behavior problems. In addition, the teacher is more likely to academically engage the child, understand the child's frustrations, and feel more able to address the needs of the child.
This simple strategy improves the likelihood of child success and can reduce teacher frustration.

**Teach social skills.** Social skills training, that is, being taught effective social interactions and appropriate social behavior, is a cost-effective, time-limited approach that often produces noticeable improvements in quality of life and interpersonal behavior. Many social skills training programs have empirical support for effectiveness.

**Promote leisure activities.** Encourage and teach productive hobbies, interests, non-academic talents, athletics, and other leisure time activities. Children who develop skills at any valued activity have enhanced self-esteem, providing a level of protection against the onset of behavioral and emotional problems.

**Enhance motivation.** Engage slow learners with attention, expectations for success, coaching, and encouragement. Academic progress may not be as fast as their classmates. However, a prime enemy of the education of slow learners is completely giving up on school and losing all academic motivation.

**Use effective behavior management.** Strong classroom management systems that are reliant on structure, explicit rules, and clear expectations are effective with all students, but especially with slow learners. Unclear rules, down time, excessive transition time, unclear expectations, and chaotic classrooms lead to behavior problems.

**Mental Health Treatment Guidelines**

**Modify counseling approaches.** Counseling young children with low intelligence can be frustrating. Historically, children with low intelligence have had mental health issues addressed with medication first because counseling was believed to be ineffective. However, there have been significant advances in effective counseling techniques for children, so counseling can be effective. However, language skills are an important factor in achieving successful counseling outcomes and children with low intelligence often have poor language skills. Therefore, modeling socially appropriate behaviors and coping skills, as well as the opportunity to engage in guided practice of the recently learned skills, is important. Modeling and rehearsal are most efficient in group therapy. There is some evidence that behavioral models of counseling and careful management of the home and classroom may be more effective than a cognitive approach.

**Promote generalization.** Often children with low intelligence have a difficult time generalizing skills from one situation to another. An important component of any social or coping skill development, or counseling session, is transferring a skill to new situations. Involving bus drivers, cafeteria workers, janitors, recess monitors, and coaches in such programs can ensure that the skills learned do not stay in the therapy room and empower these personnel to assist in reducing problem behavior and encourage skill development.

**Emphasize parent involvement.** School-based mental health resources may be more effectively targeted for parent education and parent training. Help parents provide a structured home by discussing disciplinary strategies and limit setting, providing strategies to assist in the development of academic motivation, modeling effective behaviors, and development of home behavior programs. Training parents in these skills may be the most efficient and effective methods for prevention and early intervention for children with low intelligence and concurrent behavior issues.

**Conclusions**

Intelligence is a normally distributed trait ranging from retardation through gifted, with most children somewhere midway between the extremes. Because of academic failure and limited coping skills, children with low intelligence may be at risk for severe mental health problems. Unfortunately, too many mental health facilities refuse to provide services to children with low intelligence. If they do offer services, mental health providers may not have strong understanding of how to provide counseling to a child with low intellectual ability. Schools and mental health agencies that are more responsive to these children's academic and mental health needs will help promote more positive outcomes for these children identified as slow learners.

**Resources**


**Websites**

The Association of Retarded Citizens (ARC)—
www.thearc.org/faq/series/0264.html

Steven R. Shaw, PhD, NCSP, is the lead school psychologist with the Division of Developmental and Behavioral Pediatrics, Greenville Hospital System, Greenville, SC, and is Associate Professor of Pediatrics, Medical University of South Carolina.