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Community Adjustment of Young Adults with Mental Retardation: A Developmental Perspective

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The community adjustment of young adults with mental retardation remains a crucial issue for all human service providers. No longer does adjustment imply simply the physical integration of persons with disabilities into community settings. Rather, it refers to the adjustment and integration of the whole person into community life. Whether one describes community adjustment as a process, an outcome, a philosophy, or a multidimensional concept (Bachrach, 1981), community adjustment has become synonymous with the term *quality-of-life*, a quality that depends in large part on one's happiness and success in socially sanctioned, age-appropriate tasks.

In recent years, much has changed about the way young adults with mental retardation have participated in community settings. State and federal laws, as well as precedential court cases have documented expectations that people with developmental disabilities have the right to live, work, and participate in typical community settings (e.g., Americans with Disabilities Act, PL 101-336; Developmental Disabilities Assistance and Bill of Rights Act, PL 101-496; Individuals with Disabilities Education Act, PL 101-467). Each year, proportionately fewer people with mental retardation live in institutions (63% in 1977, 41% in 1988), more live in homes with 15 or fewer people (21% in 1977, 45% in 1988) (Amado, Lakin, & Menke, 1990), and more work in integrated settings (9,882 in supported employment settings in 1986; 70,000 in 1990; Wehman, 1991). These changes have provided opportunities for ever increasing numbers of persons with mental retardation to establish their presence in integrated environments. The current challenge is to move beyond implementing strategies of physical presence to identifying mechanisms of active participation across the entire range of community settings.

Kregel, Wehman, Seyfarth, and Marshall (1986) have suggested that domestic, recreational, and community skill-building tasks serve as core elements of training programs for people with mental retardation living in community settings, but that little data exist on which to evaluate the success of such programs. The difficulty in evaluating the structure of training programs is related to the broader problems of defining facets of community adjustment for persons with mental retardation (Lakin, Brunininks, & Sigford, 1981). To address these issues, researchers at the University of Minnesota have proposed a model of adjustment based on four empirically validated dimensions: Social Integration, Recreational/Leisure Integration, Economic Integration, and Need for Support Services (Brunininks, McGrew, Thurlow, & Lewis, 1988; McGrew, Bruininks, Thurlow, & Lewis, in press). Despite the importance of conceptual frameworks, however, there is more to adjustment than simple outcomes and normative life events; as Blalock (1988) has described:

a realistic perspective requires more attention to the spectrum of abilities and needs presented by *each individual* [italics added] in each facet of life; strengths and weaknesses in all areas of living fall along a continuum that remains open to change, depending on one's experiences. (p.4)

Several perspectives defining young adults development come from the field of developmental psychology. Unfortunately for young adults, most well-known theorists such as Freud and Piaget have emphasized the early years and have all but ignored the years from adolescence onward. However, a few theorists, most notably Erikson (1968), Levinson (1986), and Havinghurst (1972), have taken a lifespan approach to the study of human development and, while they have not focused on young adulthood exclusively, have given credibility to the notion that important developmental events occur beyond the early years. In the simplest case, Erikson considered the struggle between intimacy and isolation to be a major developmental task of young adulthood. Levinson, focusing on adults of all ages, considers making choices in such areas as intimacy, employment, friendship, values, and lifestyles to be the major tasks of the transition years. For Havinghurst, young adulthood is as much a process as a time for making choices. During young adulthood one must do such things as find a mate, begin a family, and assume parental responsibilities; one must experiment with various living arrangements and begin assuming management responsibilities for a home, for oneself, and for others. A career, appropriate social networks, and civic responsibilities are additional key responsibilities of the young adult.

There is one theorist for whom young adulthood is not simply one of many stages of development, but, rather, the major area of inquiry. Chickering (1969) has outlined seven dimensions of development, called vectors, along which development occurs. The term vector implies both direction and magnitude, and refers to a sequence that Chickering believes may be more spiral than linear. Though Chickering believes there to be a sequence to one's development, the sequence is neither completely age-based nor invariant. Whether one refers to stages, tasks, milestones, or trends, Chickering has reported that all young adults have seven major areas of development in common: competence, emotions, autonomy, interpersonal relationships, purpose, identity, and integrity (p. 8). Growth

along any one dimension is not dependent on any other vector; however, unresolved conflicts at earlier stages will likely inhibit development at later stages.

Given the recent emphasis on community adjustment, the exceptionally large number of young adults with mental retardation living or preparing to live in community settings, and the near void of information on developmental components of young adulthood, an integrative study of young adult development for persons with mental retardation seems long overdue. This review of the literature is an effort in that regard. By bringing together two previously disparate areas of research, community integration and young adult development, it is hoped that the conceptual and theoretical frameworks of both will be extended. The following discussion is organized around the four domains reported in the Bruininks et al. (1988) and McGrew et al. (in press) research.

Social Integration

A conceptualization of people as inherently social animals has existed since the time of Aristotle. However, it has only been in recent years that the influence of social relationships for young adults with disabilities has received substantial attention. The importance of regular social contact with valued others, especially peers, cannot be underestimated. Social relationships contribute to one's capacity to relate to others, development of social controls, and acquisition of societal values (Hartup, 1991). Evidence has accumulated linking the quantity and quality of one's social relationships, often referred to as networks, with a wide variety of outcomes including physical and psychological well-being (Cohen & Syme, 1985). Social ties with significant others are, therefore, crucial for the successful adjustment of adults with and without disabilities (Landesman-Dwyer & Berkson, 1984). Despite recent emphases on socialization and normalization of interactions with others (Edgerton, 1967; Edgerton, Bollinger, & Herr, 1984; Landesman-Dwyer & Berkson, 1984), relatively little is known about the nature of relationships formed by young adults with mental retardation or the impact of these relationships on one's quality-of-life. Given the need for emotional support in young adults in general and young adults with mental retardation in particular, it is puzzling that the impact of social relationships to this group has not been studied more frequently.

Social relationships serve many important functions as an individual makes the transition from adolescence to adulthood. Availability of social support appears especially critical for young adults with mental retardation as they confront salient developmental tasks of identity, autonomy and independence, competence and self-efficacy, long-term vocational goals, and long-term social relationships. Research suggests that while one's social relationships with others influence and are affected by the success with which individuals handle relevant tasks, the overwhelming majority of young adults with mental retardation do not have the same opportunities for social relationships as their peers without disabilities (Abery, Thurlow, Bruininks, & Johnson, 1990). Results from recent investigations suggest that from middle childhood to adulthood, the social lives of persons with mental retardation remain highly restrictive and focus almost exclusively on family and paid caregivers (Abery et al., 1990). Few persons with moderate to severe levels of mental retardation have neighborhood or independent community-based friends (Hill, Rotegard, &

Bruininks, 1984; Hill, Lakin, Bruininks, Amado, Anderson, & Copher, 1989). Further, contacts with peers are often confined to contexts that fail to generalize to other settings and, those that are formed, often fail to provide the young adult with sufficient social support, making coping with the transition from adolescence to adulthood extremely difficult (Abery, Thurlow, Johnson, & Bruininks, 1989).

It is assumed by many persons without disabilities that the limited social contacts of young adults with mental retardation result from a lack of social skills; yet, results obtained from social skill evaluations provide evidence to the contrary. These data suggest that many young adults with mental retardation fail to develop rich social lives as a result of a multitude of barriers that exist within family and community (e.g., accessibility of services, transportation, outreach programs, public's lack of knowledge, and overprotection by significant others; see Support Services section). Findings from follow-up research suggest that physical integration alone does not guarantee that young adults with mental retardation will establish and maintain social contacts in the community (Abery et al., 1990; Rosen & Burchard, 1990). While school-based efforts to enhance social interaction between persons with and without mental retardation have met with some success, such programs are rarely, if ever available to young adults who have gone from school to employment and from home to the community. In addition to having few friends, young adults with mental retardation frequently lack longstanding companions and acquaintances who do not have mental retardation (Abery et al., 1989; Kennedy, Horner, & Newton, 1989; Zetlin & Murtaugh, 1988). A point of special concern to both practitioners and researchers is the finding that the opportunities for friendships and social relationships for young adults with mental retardation are decreasing at the very time that social skills appear to be increasing (Abery et al., 1989).

While social relationships have a direct effect on the quality-of-life experienced in the community, affiliations also have an impact on the ease with which an individual is able to traverse the many developmental tasks that accompany the transition process, tasks that are faced by young adults with, as well as without disabilities. Erikson (1963), among others (e.g., Adams & Fitch, 1982; Munro & Adams, 1977), has proposed that establishing an identity is a gradual process that extends into early adulthood and is necessary before one can establish truly intimate relationships with others (Fitch & Adams, 1983; Whitbourne & Tesch, 1985) or set and actively work toward the attainment of long-term vocational goals (Archer, 1982). The establishment of an identity, as well as one's sense of self-esteem are based to a large extent on the social give and take that occurs between the individual and significant others. Because self-knowledge and self-esteem are influenced by the way in which others perceive and react to behavior (Cooley, 1902), the restricted social lives of young adults with mental retardation can be expected to place them at a distinct disadvantage in the resolution of this crucial developmental task.

A second developmental task of early adulthood involves the exertion of increased autonomy and independence, a task that virtually all theorists consider important for the development of adult roles. As the young adult makes the transition from family to community, co-regulation, or joint decision-making with parents gives way to self-determination (Levinson, 1986; Havinghurst, 1972). For all adolescents and young adults, interactions with significant others of the same status play an important part in the

development of autonomy (Hartup, 1983). Interactions in which decisions are not imposed by those in authority provide opportunities (e.g., making choices, exertion of personal control) not always available in other contexts. For the young adult whose social network consists almost entirely of family and direct-care professionals, a lack of friends can result in fewer opportunities to exert choice, make decisions, and engage in interactions that facilitate the development of skills necessary for independence and autonomy.

Results of research on social relationships of young adults with mental retardation emphasize the passive, solitary, family-dependent, nature of their lives and suggest a need to identify programs that promote a stronger sense of identity and belonging within their community, especially programs that involve peers without disabilities in socially valued activities on a regular basis. They will need to insure that young adults with mental retardation have access to the same experiences and environments as peers without mental retardation so they can actively choose friends and acquaintances rather than have well-meaning parents or professionals do this for them. If human services personnel, educators, and families are sincerely interested in improving the quality-of-life for persons with mental retardation, opportunities to develop and maintain social relationships within integrated environments must be made available. Opportunities for social integration will provide a very important benefit for individuals without mental retardation as they learn to accept and appreciate individual differences.

Recreational/Leisure Integration

The ability to choose how to spend one's leisure time, in recreation or play, is something many young adults take for granted. From childhood, most individuals pursue a variety of sports and leisure activities that they continue to enjoy through middle- and older-adulthood. Similar to lack of opportunities in developing social relationships, young adults with mental retardation often lack opportunities in the selection and acquisition of leisure time activities (Dattilo, 1987). Because of limited employment opportunities, persons with disabilities often have more leisure time than others (Verhoven, Schleien, & Bender, 1982); yet, they participate in recreational activities less often than young adults without disabilities (Dattilo, 1987). In contrast to peers without mental retardation who often spend their free time shopping, dating, attending sporting events, or going out to dinner with friends, young adults with mental retardation have been reported to spend their free time watching television, listening to the radio, listening to records, or simply staying at home (Kregel et al., 1986). For many young adults living in community homes or institutions where leisure activities are designed by staff members, the leisure activities tend to be more passive than active (Aveno, 1987), a much different scenario than when young adults without mental retardation plan activities for themselves.

Learning through and participating in self-affirming recreational activities is critical to normal development (Chickering, 1969). Recreational activities provide opportunities for social interaction, development of self-esteem and self-confidence, experimentation with independent choices, and opportunities for individual and group activities. Leisure and recreational time can serve as an important psychological outlet, as well as a means to a healthier and more fulfilling lifestyle for young adults with or without mental retardation

(Rynders & Schleien, 1991; Schleien & Ray, 1988; Verhoven et al., 1982). For individuals becoming adults, recreational skills are essential to gaining social acceptance in everyday life. Young adults with mental retardation, similar to their peers without mental retardation, are indeed capable of learning leisure and leisure related skills (Schleien, Certo, & Muccino, 1984). Those skills may be developed in special programs of Special Olympics, International and the Unified Sports Activities in which performances of many athletes meet or exceed the performance levels of adults without disabilities.

Young adults with mental retardation frequently require more instruction, reinforcement, and opportunities to practice newly acquired skills, making it necessary to provide specific opportunities for instruction and generalization of skills in other, related settings (cf. Schleien et al., 1984). Unlike peers without mental retardation, young adults with mental retardation are less likely to have spontaneously learned play skills and more likely to need preparation for participation in integrated settings. This issue is receiving increasing attention by those involved in adapted physical education, transition, and community integration programs (Blalock, 1988; Schleien & Ray, 1988). Awareness of individual needs and personal preferences is also increasing. Just as individuals without mental retardation select and pursue their own activities in keeping with their own needs and goals, so must young adults with mental retardation. It is the sense of empowerment that allows and encourages the execution of individual choices. These choices are not ancillary to the transitional process, but, rather, a hallmark of it (Levinson, 1986). Current programs developed to enhance recreational skills of these young adults with mental retardation range from specific individualized skill instruction programs, to integrated community programs, to competitive international events such as those of Special Olympics, International.

Special Olympics, International and its affiliate Unified Sports Activities are among the most well-known and well-established sports programs for persons with mental retardation (see figure 1). Increased interaction with others, increased use of recreational facilities, enhanced visibility, and training and competitive opportunities similar to those of athletes without disabilities are some of the many benefits of these programs (Orellove, Wehman, & Wood, 1982). Despite its long history and strong community support, however, many professionals criticize the Special Olympics program for its segregation and perpetuation of stereotypes (e.g., Brickey, 1984). By providing time, training, and appropriate learning opportunities, Special Olympics and Unified Sports Activities can serve as stepping stones to other equally competitive but less segregated programs fostering successful entrance into different community programs (Dinn, Krebs, & Staur, 1989).

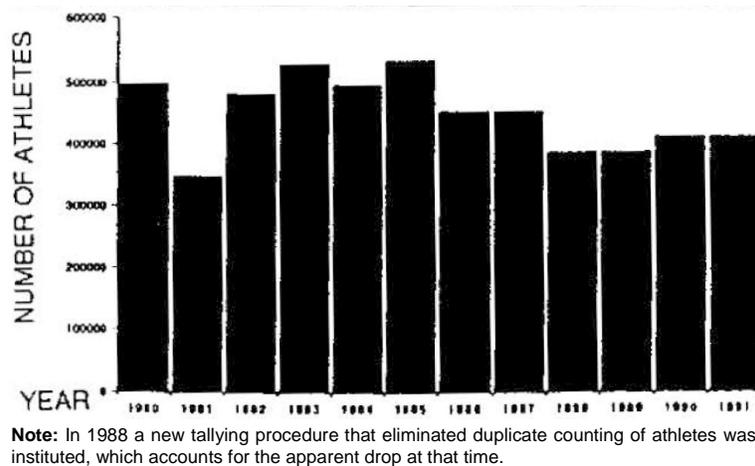


Figure 1. Number of U.S. Special Olympics participants since 1980.

Integrated recreational/leisure programs are becoming more prevalent. Led by the normalization movement, age-appropriate sports and leisure activities, training methods for overall fitness (Schleien & Ray, 1988), a variety of community agencies, outdoor adventure organizations, and community recreation centers are continuing to develop programs to facilitate integration between persons with and without disabilities (Rynders & Schleien, 1991). Literature on evolving recreational and leisure programs that stress integration into existing programs is also increasing rapidly (Dattilo, 1987; Rynders & Schleien, 1991; Wilhite, Reilly, & Teaff, 1989) as is empirical support for such programs (Reynolds, 1981; Schleien & Ray, 1988). Increased appropriate social behavior, higher skill levels due to more appropriate models, greater acceptance from peers without disabilities, and greater enjoyment in integrated activities are some of the many benefits that young adults with mental retardation gain from these programs.

In the philosophy of normalization, persons with disabilities lead lives which are as culturally normative as possible. However, to do this, young adults with mental retardation must have opportunity and freedom to learn and enjoy recreational activities in normative and nonnormative programs. Similar to the experiences of persons without mental retardation, these recreational learning experiences should begin in childhood and the skills should be ones that can be used, to the extent possible, in typical community recreational settings. For young adults who have not had the opportunity to learn such skills, the transition period can be a critical time to learn and obtain access to these and other outlets. Family, friends, and professionals involved in recreational and leisure pursuits must work together to make such opportunities accessible and possible.

Economic Integration

Community adjustment and young adult development are heavily influenced by social and recreational/leisure integration. Opportunities in both of those areas are affected by the financial resources available to young adults, however. Economic integration may be

defined as the process by which persons obtain and disburse income. This definition applies to income from multiple sources including, but not limited to, employment, income maintenance, and other sources of payment (e.g., income from personal or family assets, insurance payments, court-ordered compensation). For young adults with mental retardation, employment may include sheltered employment, group or individual employment with support services, and competitive employment at minimum wage without the assistance of a service provider (Lewis, Johnson, Bruininks, Kallson, & Guillery, 1991). Each type of employment may be either part-time or fulltime.

Young adults with mental retardation may be eligible to receive funds from Federal Supplemental Security Income or Social Security Disability Insurance, often supplemented by state income support programs. The fact that these are individual entitlements paid directly to the person or the person's representative offers opportunity for choices not often appreciated. In addition to direct cash benefits under these programs, young adults with disabilities may be eligible for Medicaid or Medicare benefits, long-term care supports such as Medicaid Home and Community-based Services, and, soon, Community Support Living Arrangements (Boggs, Haney-Maxwell, Lakin, & Bradley, 1988). Unfortunately, eligibility for public funds may be negatively affected by one's income and assets.

Not surprisingly, economic integration does not require paid employment. Unearned income, whether from public or private sources, can also provide the basis for economic integration. While paid employment may meet needs for personal income, feelings of achievement, sense of participation, and development of social relationships for some, others may choose to forego paid employment in favor of other activities, thereby challenging beliefs that adults with mental retardation must have full-time employment to make substantive choices about their own lives. Similar to points raised previously, it is important to recognize that the right to choose is an essential component of normalization and is most respected when choices with which others disagree are honored.

Two typical indicators of the transition from youth to adulthood are the establishment of short- and long-term vocational goals and the attainment of full-time employment (Erikson, 1963, 1968; Havinghurst, 1972). An occupation and the economic self-sufficiency that it produces has an impact on one's quality-of-life in both direct (increased independence and autonomy) and indirect (feelings of competence and self-worth) manners. Employment outcomes for young adults with mental retardation, although improved over past decades, remain far from optimal. For example, there continue to be many more young adults who wish to work in competitive and supported employment settings than positions available, and job loss following placement remains a persistent problem (Brickey, Browning & Campbell, 1982; Rusch, 1986). Paid employment with support services in an integrated workplace is seen as a desirable public policy goal (Dolan, 1989); but such a position is often challenged by proponents supporting the concepts of personal preference and cost effectiveness. Job retention is clearly an unresolved problem for many young adults with mental retardation as it is for many other low-skilled minimum wage employees (Schafer, Banks, & Kregel, 1991). Financial disincentives that may affect those employed are also major concerns (Schloss, Schloss, & Wolf, 1988).

While the relationship between occupation and social status has been well documented in recent years, of particular concern to the young adult with mental retardation is the

access that economic integration allows in other areas of adjustment. For example, when workers with disabilities lose jobs, social inadequacies and social skill deficits are among the most frequently cited reasons (Salzberg, Lignugaris-Kraft, & McCuller, 1988). Lack of a supportive network of friends upon whom to model one's behavior may be a factor that contributes to these deficits. Research results also suggest that in the work setting itself, the majority of contact between workers with and without mental retardation is concentrated on job performance with very little contact between employees during breaks or after work hours (Shafer, Rice, Meltzer, & Haring, 1989). Without opportunity to develop social relationships with co-workers, young adults with mental retardation do not have the social support necessary to cope effectively with work-related stressors. Whether through membership in special interest clubs, sports teams, or group attendance at single events, contacts made in the workplace may become first steps toward participation in various recreational and leisure activities. Unfortunately, most organized recreational activities require money (e.g., dues, admissions, equipment, uniforms, etc.), an unpleasant but reality-based responsibility of adulthood. It is of particular importance that such costs be paid by the individual, from personal income or resources, if participation is to be regarded as normal or similar to peers without mental retardation.

Finally, economic integration requires that, to the extent possible, young adults with mental retardation retain the right to manage their own income. Agreement with this principle is easily gained; more difficult is its acceptance in practice. Is the right to spend money foolishly included? May a young person with mental retardation demonstrate the same degree of disinterest in healthy diets as persons without mental retardation? Must young adults with mental retardation buy sensible clothing while all others seem to invest in disposable (and forgettable) fashions of the moment? Should the young adult with disabilities be allowed to choose a place of residence because of price alone, even when it is in a potentially dangerous neighborhood? These are many of the questions that must be resolved in the minds of service providers before expecting persons for whom they are responsible to do the same. While community adjustment of young adults with mental retardation is indeed facilitated by one's level of economic integration, traditional definition of economic integration should be expanded to include options and sources of income and disbursement other than simply paid employment.

Need for Support Services

All young adults, including those with mental retardation, need a place to live, supportive social networks, opportunities to participate in meaningful and self-fulfilling activities, and resources to meet financial obligations and desires. However, young adults vary in their ability to meet these needs. Many young adults without mental retardation are able to obtain and maintain an apartment, develop friendships, find fulfilling ways to spend non-work hours, and earn enough money to support themselves. Others, however, require ongoing or at least intermittent family support to obtain balanced meals, clean laundry, basic medical care, or even to manage a personal budget. Like young adults without mental retardation, there is great variation in skills young adults with mental retardation bring

to tasks of independent living. Some are able to live with minimal support from family or friends; others require moderate to extensive levels of assistance and support.

While individual support needs vary widely among persons with mental retardation, some studies have suggested common elements. In one survey of approximately 13,000 persons and families of persons with mental retardation, respondents were asked to indicate services and supports needed for independence, integration, and productivity (Temple University Developmental Disabilities Center, 1990). Two other studies have identified types of support services used by people with mental retardation living in different types of settings. One examined supports used by individuals living in foster homes, small group homes, and small Intermediate Care Facilities for the Mentally Retarded (Hill et al., 1989). The other examined supports used by persons living in private residential settings of all sizes and large public institutions (Hill, Lakin, Sigford, Hauber & Bruininks, 1982). The findings of these studies are summarized in table 1.

Table 1. Support Services Used or Needed by Persons with Mental Retardation

Type of Support	Supports Needed National Consumer Survey ^a	Proportion Using Support in a One-Year Period		
		Small Community ^b	All sizes Private ^c	Public Institutions ^c
Physician	67%	99%	97%	100%
Dentist	66%	95%	83%	96%
Transportation	50%	62%	68%	16%
Social/Recreation	55%		61%	35%
Social Worker/Case Manager	60%	62%		
Income Assistance (i.e., SSI)	55%			
Payment or Provision of Medication	52%			
Medical Specialist		49%		
Health Insurance	46%			
Nurse	12%	38%		
Speech/Communication	40%	33%	23%	17%
Payment or Provision of Medical Equipment/Supplies	37%			
Psychologist		32%		
Physical Therapist	33%	20%	11%	19%
Nutritional/Dietician		19%		
Occupational Therapist	32%	15%	11%	16%
Professional Counselor	24%	10%	25%	15%
Advocacy	34%		4%	5%

Note: Small community facilities housed 1 to 6 persons with mental retardation. National Consumer Survey results include responses identified by 30% or more of the respondents. The absence of a value in any category means that the use of this type of support was not evaluated in the study. a. $N = 13,075$; Temple University Developmental Disabilities Center, 1990; b. $N = 336$; Hill et al., 1989; c. $N = 964$, $N = 997$, Hill et al., 1982.

Most frequently reported support needs identified across all three studies were as follows: physicians, dentists, transportation (for both work and leisure activities), social and

recreational services, case management services, income assistance. While some requested supports are common to young adults with and without mental retardation (e.g., medical and dental services) and some can sometimes be obtained through generic community resources (e.g., transportation), other specialized support services are used by persons with mental retardation almost exclusively. To reach the goal of full integration in social, recreational, and economic environments for young adults with mental retardation, adequate and integrated community-based support services must be made available. Some of the most important support needs in each area of community adjustment are noted in the following paragraphs.

Many supports are needed to enable young adults with mental retardation to achieve social integration. Two of the most salient needs for social integration are in the areas of transportation and social connections. For social integration to occur, persons must first have reliable transportation to and from activities and the people who form their social network. Transportation must be available evenings and on weekends when most social gatherings occur. The National Consumer Survey estimated that more than 50% of respondents required transportation assistance for recreational and leisure time-activities (Temple University Developmental Disabilities Center, 1990). Another major support needed by young adults with mental retardation is someone who will help them make connections with people in typical settings with similar interests. The National Consumer Survey estimated that approximately 34% of persons surveyed needed a companion, friend, or advocate for adequate adjustment to community living (Temple University Developmental Disabilities Center, 1990).

Transportation and access to a benefactor are also important in the area of recreational/leisure integration. Beyond these supports, however, young adults with mental retardation also require support to develop skills in life-long leisure activities valued by young adults without mental retardation. In the National Consumer Survey it was estimated that 55% of people with mental retardation surveyed needed recreational and leisure services (Temple University Developmental Disabilities Center, 1990). If the goal is to provide integrated recreational and leisure experiences for young adults with mental retardation, then skills training for teenagers and young adults with mental retardation must be referenced to activities valued by peers.

In the area of economic integration, many types of support are needed; however, the most obvious support is access to adequate income that allows one to meet personal needs (e.g., social, recreational, medical). According to the National Consumer Survey, 55% of those surveyed required income assistance, 28% vocational training services, and 28% employment services (Temple University Developmental Disabilities Center, 1990). While paid employment is not always necessary, young adults with mental retardation need support and training in the acquisition and maintenance of income leading to financial independence. In some cases, this goal can be achieved through integrated supported employment. In other cases, this goal can best be met by encouraging and actively supporting decision-making skills regarding the use of existing financial resources.

Conclusion

Several approaches to the study of community adjustment have been conducted over the years, but few, if any, have examined the development of young adults with mental retardation relative to developmental tasks for young adults in general. Several prominent themes have emerged from this review: (a) Community adjustment is as much a process as a product and, as such, dictates that service providers consider wishes, needs, and abilities of young adults as persons first when planning and providing community services. (b) Beneath the broad construct of community adjustment lie several separate but inter-related dimensions. Efforts to assist with integration in any one dimension impact heavily on the level of adjustment in each if not all other areas. For example, level of social development influences to a large degree the kind of recreational and leisure activities in which one is likely to participate. In addition, one must consider many practical limitations of low levels of economic integration on such things as recreational and leisure integration, social opportunities, and number of support services. (c) Although need for support services comprises one of the four dimensions presented in the Bruininks et al. (1988) model, the presence of barriers in any one dimension will very likely implicate and preclude development in any or all of the other dimensions. (d) The developmental work of theorists such as Chickering, Erikson, Havinghurst, and Levinson, although useful in a normative sense, overlook many of the obvious challenges accompanying pervasive disabilities such as mental retardation. The challenge for service providers, then, is to refrain from discounting the many wonderful contributions of these prominent theorists and continue finding ways to use and modify their developmental frameworks to better understand and improve community services for young adults with mental retardation.

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