

Genetic Analysis and Characteristics of Down Syndrome

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DESCRIPTION

The treatment of Down's Syndrome (DS) costs between one and two billion dollars per year, and the condition now accounts for more than one-third of the severely to moderately retarded population. The disorder's prevalence is increasing as medical science improves the chances of survival for high-risk DS infants and also when the average maternal age is said to be rising and preventative measures are still not widely used as a result, training and habilitation programming for the DS population must be expanded on several fronts, including reflecting the growing number of cases at all ages, the increasing proportion of adults to children, and the widening distribution of IQ levels regardless of age. There will be increasing pressure on existing care facilities, as well as a need to match advances in pediatric care with a better understanding of the syndrome's psychological potential at various stages of growth and decline. Some experts believe that preventative public health measures based on cytogenetic screening and pregnancy termination are preferable to further development of care services and techniques. Compulsory control measures, because the major structural and process disorders of DS are laid down embryologically and are developmentally prescribed to a significant extent from birth onward, the absolute cure is unlikely. The primary goal is to provide a critical overview of the massive behavioral literature on DS to identify links between biological and psychological phenomena, in the belief that improved care systems will necessitate such a foundation. Because the best research evidence is recent, the task has not previously been undertaken in any comprehensive manner. It is not unfair to suggest that most psychological studies before the loss could be discarded with no significant loss of practical understanding. A second goal of the book is to encourage parent organizations to become more involved in the field of mental retardation NFU management. These groups inherited a slew of myths and half-truths about Down's syndrome.

Characteristics of trisomy 21

Contemporary behavioral images that have persisted in the clinical literature are largely based on institutional data. We

know a lot less about how DS adjustment capacities manifest themselves over years of home care and community life. We need to know if the classic stereotypes have substance and how much they can be changed by physical and psychological intervention occurring right in the object of remedial rather than purely maintenance concern. Considerations from the past most authorities' credit with providing the first comprehensive description of mongolism the theories on etiology, prognosis, and treatment included a genetic regression hypothesis about causation and a control program designed to exploit the class members' alleged imitative ability and good observational facility for racial regression Although a scientific nightmare, the human chromosomal its evolution is not entirely improbable. Moreover Down's ethnic classification of developmental disorders as proof of humanity's unity is ingenious for the time. Other physicians were also involved in the search for order among developmental disorders. Because their appearance and behaviour were similar, cretins were grouped for treatment purposes. Better nutrition, fresh air, and regular exercise were recommended and later Seguin developed a training regime for children with imbecile intelligence moderate MR whose condition was caused by an exogenous factor. Those referred to as feebleminded or educable MR in cultural terms were isolated early in the twentieth century and thought to be the result of improved genetic stock. For socio-educational purposes, they were viewed as more or less homogeneous. The clinical-genetic, traumatic, polar failure to investigate the relationship between cause and consequence in mental retardation was due to several factors. Because biological sciences were in their infancy in the nineteenth and early twentieth centuries, the cure movement of the nineteenth and early twentieth centuries failed. They were then unable to support effective treatment on a bio-behavioral and syndromic or causal basis. What remained was an amorphous collection of intractable mental handicaps, for which the economics of custody took precedence the industrial urbanization had resulted in a concentration of poverty and crime, which the average citizen came to associate with social and academic incompetence. The introduction of compulsory schooling to prepare a technically competent workforce genetic, and cytogenetic classes of developmental arrest make up the majority of what

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is now known as mental retardation. The various MR causal categories are still not readily recognized as discrete for treatment and prevention. Even though they share more than a general inability to cope with academic and productivity standards in the community, the various causal categories of MR are still not readily recognized as discrete for treatment and training purposes. The various categories of developmental disorders were now easily grouped under one label those who couldn't learn or earn. The concern was to isolate affected individuals to protect private property and the integrity of the

new educational system. Popularization and misrepresentation of biological evolution precepts, as well as a fear that genetic inferiority is replicated in the population at a disproportionate rate, served as additional motivators. The pioneering mental testing movement's discovery that up to 25% of all schoolchildren have learning disabilities served to strengthen the public case against the mentally retarded. As a result, the fundamental dissimilarity of the many disorders comprising the new MR category was irrelevant, and routine custodial programs were implemented.