Emotional Disturbances and Mental Retardation

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EMOTIONAL DISTURBANCES
AND
MENTAL RETARDATION

BY

JEANNIE WILLIARD ERVIN
B.S., Florida State University, 1975

SPECIALTY PAPER

Submitted in partial fulfillment of the requirements for the degree of Master of Science: Psychology in the Graduate Studies Program of the College of Social Sciences of Florida Technological University at Orlando, Florida

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Acknowledgments

I would like to thank Dr. John McGuire for his patience and for chairing the committee. I would also like to thank Dr. Charles Unkovic and Dr. Janice Midgett for their time spent on the committee.

I would like to dedicate this paper to my parents for always encouraging me in whatever endeavor I pursued.
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Introduction

This paper will explore the psychological problems and symptoms that confront the mentally retarded and will focus on those individuals who are classified as retarded. Through an extensive review of contemporary literature, an attempt will be made to answer the question, "Is psychotherapy effective in dealing with the emotionally disturbed mentally retarded?"

Emotional disorders in the mentally retarded are referred to by many authors, but few systematic studies have been done to deliniate the nature of the psychopathology or problems that confront the retarded individual. Similarly, there have been few comprehensive investigations into the need and effectiveness of various psychotherapies in dealing with emotional problems among the retarded.

Traditionally, behavior modification was the only form of therapy extensively practiced with mentally retarded. Also, behavior modification by definition is concerned only with external behavior not with internal dynamics. For these reasons, behavior modification techniques are only briefly examined in this paper which will focus on other directive, non-directive, group and individual approaches to therapy with the mentally retarded.
Past Definitions of Mental Retardation

Since the 1940's, definitions regarding mental retardation contained ideas, theories and even wording that today are considered inaccurate and as contributing factors in the negative stereotypes often applied to the mentally retarded today.

Doll (1941) defined mental retardation as a state of social incompetency obtained at maturity resulting from developmental arrest of constitutional origin. He then went on to say that this "condition" was incurable through treatment and unremediable through training except in teaching superficial and temporary compensations for the retarded person's limitations.

In 1952, Brenda described a mental defective as being a person who was incapable of managing himself or his affairs, or being taught to do so and who requires supervision, control, and care for his own welfare and the welfare of the community.

These definitions may help to promote the attitude that retarded people are completely incapable of learning or living independently. In addition to these past definitions, terms such as idiot, imbecile, and moron were coined to differentiate between levels of retardation. These terms, rarely used today, have now been replaced by mild, moderate, severe, and profound in reference to degree
of retardation.¹

Present Definitions of Mental Retardation

As defined by the American Association on Mental Deficiency, a mentally retarded individual is a member of a subgroup of the general population which has significantly subaverage general intellectual functioning existing along with deficits in adaptive behavior, and which were manifested during the developmental period (Grossman, 1973). Individuals who become retarded later in life as a result of an accident or disease are not included in this definition.

This definition includes all levels of mental retardation. In order to become more precise in determining levels of mental retardation, the AAMD adopted the following classifications and corresponding intelligence test scores to indicate the different levels of mental retardation (Sears, 1975):

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IQ, as it is identified with intelligence refers to processes such as the rate and amount of learning ability, the capacity to acquire information, and the ability to deal with new situations. IQ tests, per se, permit only general inferences about these functions.

The second element in the definition of mental retardation deals with the consequences of below normal general intellectual function. Adaptive deficits are seen in terms of maturation, learning, and social adjustment (Hardy and Cull, 1974). Adaptive behavior is defined as the ability to adapt to and control one's environment (Grossman, 1973).

The third element in the definition concerns the period of time in which the deficits in intelligence and adaptive behaviors manifest themselves. As was mentioned earlier, these deficits must be manifested during the developmental period which is defined as the period of time from conception to approximately 16 years of age.

Characteristics of the mild level of mental retardation include problems with language elaboration, concrete approaches to problem solving, and abstract thinking. The mildly retarded individual must cope with the effects of labeling, self-fulfilling prophecies, and effects from their family—overprotection or rejection. Learning difficulties present the retarded individual with a constant source of anxiety concerning his inability to
integrate the major societal ramifications of being labeled as a retardate at a crucial age when the self-concept should be firming up; instead, stresses tend to establish excessive personality defenses against potential external dangers to the self.

**Emotional Disturbances**

Chess (1952) described emotional disturbance as any significant emotional deviation that causes the retarded to have difficulty in meeting or adjusting to the demands of society, or in achieving an effective relationship with the environment in which he finds himself. The emotional states involved may range from severe tensions to overt psychotic behavior.

To this definition of emotional disturbance we would like to add that the majority of cases of emotional disturbance can be subsumed under the following:

**Conduct disorders**, characterized by chronic disobedience, fighting, temper tantrums, poor interpersonal relationships, and inadequate guilt feelings (American Psychiatric Association, 1968).

**Personality disorders**, characterized by feelings of inferiority, social withdrawal, anxiety, depression, and hypersensitivity, impulsiveness, and explosive outbursts of rage (American Psychiatric Association, 1968).
Socialized delinquency, characterized by engaging in gang activities, stealing, truancy, and hostility towards authority (Quay, 1972).

Neuroses, characterized by anxiety, fear, compulsiveness, depression, and fatigue (American Psychiatric Association, 1968).

Psychoses, characterized by hallucinations, delusions, profound alterations in mood, and deficits in perception, language, and memory (American Psychiatric Association, 1968).

The Relationship Between Mild Mental Retardation and Emotional Disturbances

The retarded individual is vulnerable to abnormal personality development not only because of his or her constitutional endowment, but because of their interpersonal experiences with the environment. They are repeatedly confronted with tasks that they are intellectually ill-equipped to handle, and build up a higher expectancy of failure than other people (Chess, 1962).

Emotional problems are generally the same as those occurring in people of normal intelligence (Philips, 1967; Philips and Williams, 1976). Symptoms may be influenced by retardation, but this is understood in terms of the retardate's assumed relation to life experiences. If the retarded individual is overwhelmed by his condition and/or emotional disturbance, it may result in self-deprecation, inhibition, and withdrawal. There might be a reaction of
explosive aggressive behaviors.

Mildly retarded individuals comprise 85-90% of all the mentally retarded. Greater degrees of retardation usually bring less struggle with reality (LaVietes, 1978). Glasser (1967) and McEver (1969) note that children and adolescents with mild degrees of retardation often recognize the overt or covert rejection by peer and elders; the feelings of inadequacy, hopelessness, as well as rejection may find their expression in various psychopathological symptoms.

One grave problem occurring in the area of emotionally disturbed mentally retarded was the tendency of many in the professional community to evaluate a person as either mentally ill or mentally retarded, not both. Menolascino (1977) stated that a child's symptom of mental retardation was viewed as a signal not to treat accompanying emotional disturbance, and that according to the practices of many child psychiatrists, psychiatric diagnosis must be made in terms of either "retardation" or "emotional disturbance". This view seems unable to conceive of a combination of the two. Menolascino continued to say that it is irrational to assume that a person with evidence of mental retardation should not be offered psychotherapy. The results of therapy are in proportion to the amount of psychopathology. He concluded that the decision of whether or not a person should receive psychotherapy depended on the estimation of
his ability to profit by it regardless of the presence or absence of mental retardation.

In an attempt to differentiate between adjectives used to describe mentally ill or mentally retarded populations, Cleland, Manaster, King, and Iscoe (1975) illustrated the attitude that the two areas were significantly different. In their study, a 300 word adjective check list was given to 215 professors, graduate students, and upper division undergraduates in educational psychology and special education departments. The results indicated that no adjective in the top ten of one group was included in the top ten of the other group. Regardless of the results, the study illustrated the popular attitude that mental illness and mental retardation were two clearly definable and different conditions.

Psychotherapy and Mental Retardation

Psychotherapy is a broadly defined, diversely used term. LaVietes (1978) defines it as a systematic, theoretically based psychological technique utilized by a professionally trained person for the purpose of effecting behavioral or personality change in another person. Psychotherapy varies widely in the methods, materials, procedures, theoretical substrate and the skills and training of the therapist,
Sternlicht (1966) felt that there are basically two schools of thought concerning the use of psychotherapy with the mentally retarded. One is that due to limitations and deficits in the retardate's mental and emotional constitution, psychotherapy is, as a whole, ineffective and therefore a waste of time. The other school of thought emphasizes that psychotherapy can be of assistance to the mentally retarded especially those who are verbal and are aware of their handicaps. Lott (1970) believed that it was a mistake to assume that mental retardation, with its associated dimension of limited comprehension, was a firm barrier to the use of psychotherapy.

After reviewing the literature, Sternlicht (1966) concluded that despite these arguments, it must be recognized that the mentally retarded were subject to emotional trauma incidental to their intellectual deficits and that they responded in varying degrees, to psychotherapy. Potter (1971) later said that there was a desperate need for psychiatric care with the mentally retarded. He stated the following: the Report of the Joint Commission on Mental Illness and Health largely ignored mental retardation; less than 1% of United States psychiatrists are attached to the staffs of state schools and institutions, nearly 50% of these are on a relatively inactive consultant basis; and only 5.5% of the patients seen in 1,000 psychiatric clinics
were mentally retarded.

These views seem strange when compared to the relative frequency of emotional disturbances occurring in the mentally retarded as compared with the general population. The Joint Commission on Mental Health in Children (1969), reported that 14-18% of the general population were emotionally disturbed. In studies by Menolascino (1965) 30% of the mentally retarded had major psychological problems, only 10% were reported as normal. Chess and Hassibi (1970) and Philips and Williams (1975) reported studies in which 40% and 87% of their respective retarded subjects were found to be emotionally disturbed. The IQ ranges of these retarded subjects were not mentioned.

**Incidence of Emotional Disturbances in the Mentally Retarded**

In a study by Philips and Williams (1975), 100 mentally retarded individuals of various ages with and without emotional disturbances and ranging from severe mental retardation to mild in intensity were evaluated by a psychiatric clinic that provided a wide range of services.

One hundred and eight consecutive admissions to the clinic were evaluated; eight dropped out before the study was completed. The subjects were diagnosed according to the etiology and severity of their mental retardation.
The study found that psychological problems were related to the degree of mental retardation—the lesser the degree of retardation, the greater the severity of the emotional disturbance. This may be due to the higher level of the mildly retarded person's awareness of his being "different" and the inability of the individual or society to deal with that. Philips and Williams added that they found that 38 of these children were psychotically disturbed, 13 had no evidence of psychiatric disorder and 49 showed symptoms of characterologic, neurotic, behavioral or situational disorders. Although the incidence of emotional disorder was high among these retarded subjects, their symptoms were the same as those found in a group of non-retarded children referred to the clinic.

The report offered no explanation of objective measures and methods used in determining the presence and severity of emotional disturbance. Also, the fact that the retarded were referred to a psychiatric clinic may indicate a biased sample of mentally retarded since it would seem likely that most people referred to a psychiatric clinic would evidence some emotional disorder.

Cytryn and Millowe (1970) felt that the development of emotional disturbances in mental retardation often begins with transient situational problems that become more fixed as the retarded child's development is distorted. These
differences combined with negative social experiences may make a less acute problem intense as the mentally retarded child develops. They added that one must also consider the problems involved with parental reaction to having a mentally retarded child and the total effect of these problems upon the retarded individual were the causes of the high incidence of emotional disorders in the retarded.

Cytryn and Millowe assigned the risk of mental illness in the mentally retarded as high as 40%. In their own study, in a control group of 79 children of normal intelligence referred to their clinic, only 18% were evaluated as evidencing psychotic behaviors as compared to 38% of the mentally retarded subjects. Again, these figures may be inaccurate due to the fact that the subject populations were referred to a psychiatric clinic and therefore were not random samples. Also, there was no mention of evaluation methods or procedures.

Menolascino (1977) broke the percentages down even further and stated that in children institutionalized with Down's syndrome, 37% were emotionally disturbed. At the time of admissions to a retardation institution, 56% of all new admissions were emotionally disturbed; the author felt that placement in a mental retardation institution was inappropriate because of the traditionally meager number of mental health professionals at such institutions,
He also reported that of those mentally retarded living at home with their families, 20-35% evidenced emotional disturbances. The evaluation procedures used were not explained.

In a study regarding institutionalized retardates, Menolascino (1977) found that 191 of the 616 residents studied displayed prominent psychiatric problems. One hundred and fifty one were considered to be both mentally retarded and emotionally disturbed. Forty were considered to have primary emotional disturbances causing a depressed IQ.

In this study, no evaluation techniques were described nor was there any explanation of how it was determined whether a person was retarded with an emotional disturbance or emotionally disturbed with secondary functional retardation or what differences occurred between the two groups and how these differences were determined in the first place.

Repeatedly, the question arises, "are the figures of emotional disturbances occurring in the mentally retarded spuriously high?" In another study (Chess, 1952), 52 children, ages four to six years, living in a group home were studied. IQ's ranged from 50 to 75. This study required mildly retarded subjects who had to come from middle class backgrounds. Considering socioeconomic status in obtaining subjects introduces a confounding
variable into the study. In the results of the study, 60% (or 31) of the 52 children had some evidence of an emotional disorder; still it is possible that the reasons involved in putting the children in a group home pertained to the existing emotional disturbance as well as to the mental retardation, therefore raising the percentage of emotionally disturbed out of proportion.

Webster (1971) reported on a study involving 159 children, ages three through six who were in for routine evaluation at the Preschool Retarded Children's Program of Greater Boston. Results indicated that not a single child was "simply retarded". None had the emotional development comparable to a nonretarded child of the same mental age. Webster rated 35% of the children as mildly disturbed, 48% as moderately disturbed and 17% as severely disturbed; however, nothing was mentioned as to how these children were rated. The subjects were described as expressing the following descriptive features: autism, repetitiousness, inflexibility, and passivity. Webster stated that these characteristics were more consistently associated with mental retardation than with any other diagnostic factor. He did not say how it was associated or what relevance this had to his study.

Gardner (1966) did not support the view that the emotional adjustment level of mildly retarded children and
adolescents was inferior to the adjustment level of nonretarded children. In a critical review of the literature, Gardner stated that previous research studies concerned with social and emotional adjustment characteristics, which showed that emotional disturbances among the mentally retarded had a high rate of occurrence, were inconclusive. He felt that contrary to the number of statements appearing in various texts and review articles, little is known concerning the type and frequency of occurrence of emotional adjustment problems among the mildly retarded. In reviewing the evidence, he felt that little available information focused directly on the question of the occurrence of emotional disturbances in noninstitutionalized mildly retarded children and adolescents. The majority of studies reviewed dealt with the institutionalized retarded, and these, it was felt, would not be characteristic of the retarded residing in the community. Gardner also made the criticism that several studies concerning the behavioral and emotional adjustment of the mentally retarded dealt with subjects who had intelligence quotients in the 80 to 89 range and therefore were not representative of the retarded population.

In many areas of Gardner's critical review, he offered only criticism of the studies presented; he did not offer any supporting evidence for his hypothesis that adjustment levels between mildly retarded and normal populations might
be the same. In fact, all that can be inferred from Gardner's report is that this is a question still largely unanswered and an area for future research.

Characteristics of Emotionally Disturbed Mentally Retarded

Neuroses

Chess (1970) stated that neurosis among the mildly retarded was more common than among the general population or among those individuals with greater degrees of mental retardation. The symptoms of neurosis, however, were the same as those occurring in the normal population. Anxiety was the chief characteristic of neurosis. It could be repressed or openly expressed. In contrast to psychoses, neuroses did not result in distortion of the perception of reality nor severe personality disorganization. The neurotic individual was usually aware that his mental functioning was disturbed (American Psychiatric Association, 1968). Many neurotic mentally retarded individuals typically fall under one of the categories of obsessive compulsive, depressive, and hypochondriacal.

Glasser (1967) stated that individuals with mild retardation often recognize their inadequacy and the overt or covert rejection by society. These people may have a realistic appraisal of their position in life, but their lack of verbal abilities and external supports limit them
in either correcting their inadequacies or compensating for them. These feelings of inadequacy, as well as the rejection by others, may be expressed as symptoms of depression; very often, however, these feelings produce anger against the environment.

**Personality Disorders**

This group of disorders is characterized by maladaptive behavior patterns that frequently manifest themselves by adolescence or earlier. Menolascino (1970) noted that personality disorders that occur in mental retardation are primarily based on extrinsic factors and have no distinct etiological relationship to mental retardation. The frequency of the occurrence of personality disorders in the mentally retarded is not any greater than in the general population. Menolascino did not offer evidence to support his conclusions.

**Psychoses**

The presence of a functional psychosis in a person who is functioning at a retarded intellectual level has been a problem to etiological, diagnostic, and treatment considerations. Psychoses are characterized by gross impairment in functioning to meet the ordinary demands of life; hallucinations, delusions, and radical alterations of mood may also be present. The psychoses can be broken down into three basic categories of schizophrenia, major affective disorders, and paranoid states (American Psychiatric Association, 1968).
Menolascino (1969), in a study of emotional disturbances in mentally retarded children, described those with functional psychoses as displaying withdrawal, bizarre motor posturing, ritualistic mannerisms, marked preoccupation with inanimate objects, and periods of apparent loss of contact with the environment. Out of a sample of 256 emotionally disturbed mentally retarded children, 51 were classified as having psychotic episodes. However, Minolascino did not describe evaluation technique or give a detailed description of the retarded population.

**Transient Situational Disturbances**

This category involves those disorders that are more or less temporary, that occur in individuals who have no apparent mental disorders, and that represent a severe reaction to overwhelming environmental stress (American Psychiatric Association, 1968).

Chess (1970) stated that the mentally retarded were especially sensitive to this disorder because of their limited ability to adapt and conform to new situations.

In Menolascino's study, mentioned earlier, 58 of the 256 children were diagnosed as being in this group. Primary symptoms included obstinancy, enuresis, temper tantrums, disobedience, stealing, and masturbation against a background of anxiety, cognitive developmental delays, and mild language retardation. Often these symptoms hinged on
child-family relationship; frequently, parental dissension produced anxiety and confusion in the child followed by massive insecurity. The child from an insecure and nonsupportive family has a much greater likelihood of responding to transient situational disturbances than a child from a warm, accepting environment and also has much less likelihood of being able to successfully overcome such reactions.

Factors Associated with Emotional Disturbances in Mental Retardation

In a study by Chazan (1965), the incidence, nature, and etiology of emotional disturbances in mildly retarded children were investigated. In this study, the 30 most maladjusted children in a larger sample were compared with a control of 30 least maladjusted children. There was no mention of how the larger sample was obtained other than that they came from schools in South Wales. There is also a question as to whether the control was an unbiased control group, since they were selected from a group of retarded children as being the best adjusted.

The most maladjusted and best adjusted children were selected by the use of arbitrary scores on the Bristol Social Adjustment Guide. The mean score for the maladjusted group was 30.20 and 6.37 for the control group.
The primary factors found to be associated with the maladjustment seemed to be socioeconomic status, physical factors and adverse psychological conditions at home. Twenty four of the 30 maladjusted children were below average in socioeconomic status, whereas only ten of the control group were. Twenty five of the maladjusted group versus 12 control had either an unsatisfactory physical condition, physical defect or an appearance that aroused negative reaction. Twenty seven of the treatment group as compared to 12 in the control group had adverse psychological conditions at home. These included parental rejection, instability and general family unhappiness.

Chazan stated that comprehensive guidance services for families of mildly retarded children could result in better emotional development for the children. The prevention of situations conducive to maladjustment might be helped by special centers where parents of retarded children could obtain expert guidance at an early stage of the child's development.

Treatment and Management

There are many different approaches and beliefs concerning the various therapeutic procedures and techniques regarding counseling with the mentally retarded. Wicas and Bidwell (1974) asserted that time was crucial because there may be a limit to the period of time that a retarded person
may remain in one home or institution. Institutional youths may require much more intensive counseling than either the general population or most mentally retarded in the community. Frequently, insight therapy may be unrealistic because it is founded on the idea that the individual is capable of intellectual growth which by definition is limited. Also, Wicas and Bidwell expressed concern that the mentally retarded usually have very negative self-concepts and felt that it was necessary to change the retardate's attitude toward self to facilitate counseling.

Wicas and Bidwell saw advantages in both group and individual counseling techniques. Counseling in groups permitted opportunities for the retarded to express some degree of social intimacy not otherwise experienced as well as the opportunity to focus on the therapeutic tasks of clarifying and understanding feelings and attitudes. It was thought that individual counseling permitted the opportunity for the therapist to target in and work to alter a specific behavior or attitude. They concluded by saying that family group counseling has an essential role in helping the mentally retarded and their families.

Many of the ideas that Bidwell and Wicas support are self evident; however, there should have been some supporting evidence to their statements. Also, the statement that family group counseling is important in
helping the families of the retarded was made, but no other explanation of how it would help was given.

Sternlicht (1966) wrote that after reviewing pertinent literature, he felt that the most important aspect of counseling with the mentally retarded was not whether it was group or individual therapy, but rather that the procedures be nonverbal in view of the limited intellectual functioning of the clients.

Hellinger (1963) saw the basis for effective counseling with the mentally retarded as a complete understanding of the client's personality. A study of personality discloses what assets and liabilities the individual possesses. It also reveals what kind of adjustments he has made or needs to make in relationship to his basic feelings and needs. Hellinger continued to say that a personality study of the retarded client gives the counselor a picture of the motives of the individual and indicates what medical, psychological, or other professional assistance is needed. This statement should require some supporting evidence. It is highly unlikely that understanding someone's motives will indicate what medical assistance is needed.

Stacey and DeMartino (1957) considered the personality of the counselor to play a vital role in the resulting success or failure in counseling. The basic aspects of therapy with the retarded included release of emotions,
need gratification, giving support, respect and reassurance, by improving insight, by providing receptive authority figure, and by having the client develop a positive self-concept.

Stacey and DeMartino felt that therapeutic approaches in dealing with mentally retarded clients must be modified for the best results. The counselor must speak in terms at a level that the retarded client would understand. Also, he needs to be responsive to subliminal cues and autistic gestures because of the mentally retardate's inability to express feelings or thoughts clearly. Sometimes either nondirective or directive therapy will be effective with a particular client or clients; however, the authors felt that directive worked faster and more effectively the majority of the time. In this article, the authors did not present any object measures to support their conclusions.

Yepsen (1952) recommended that the counselor should be eclectic and use whatever method of counseling that would be the most successful with a particular client. He felt that the aim of counseling was to further the development of an adjustable individual who could adjust to new situations that he might encounter. The counselor must also set reachable goals for the client and must remain alert to his own limitations.
Individual Counseling

Hellinger (1963) felt that only in a one-to-one counseling approach can there develop the closeness necessary for effective personal development when dealing with a mentally retarded client population. The counselor needs to provide security in the counseling relationship to facilitate the development of the trusting and accepting atmosphere where change can take place.

Hellinger described the counseling program she is involved in at a halfway house for mildly retarded girls as neither directive nor nondirective since at times either one method or the other was used. Different techniques were found more or less useful with different individuals and in different situations. The counselor, however, was always the facilitator, guiding the client through whatever aspect of therapy is present.

In this program informal counseling took place more frequently than formal counseling with the counselor taking advantage of incidental opportunities which arose to help the resident cope with her problems. During formal sessions, an inability or reluctance on the part of the client to verbalize difficulties was noted. The counselor would then divert the conversation to nontargeting subjects until the client referred again to the subject that troubled her.
This approach to therapy is largely impractical, since few counselors can make themselves as accessible to the clients as a resident counselor can. In Hellinger's report there was no attempt to objectively report therapy methods or the amount of time spent with each client which could make it difficult if not impossible for someone to evaluate or to duplicate her method of counseling. Since this program was still in process, no accurate pre and post treatment data could be given, though Hellinger did state that the clients involved did evidence an improvement in emotional adjustment. She also indicated that it was likely that the majority of institutionalized mentally retarded girls would be emotionally disturbed and exhibit neurotic or psychotic symptoms. Whether or not this is a fact is not in question; Hellinger should have given research evidence to support such a sweeping statement.

Peins (1967) felt that the communication problems of the mentally retarded led to frustration and eventual acting-out behavior. Her study is a descriptive account of an individualized therapy program used with ten institutionalized, mentally retarded, delinquent adolescents who were deficient in areas of verbal communication. The clients ranged in ages from 13.2 to 16.1 years. The mean IQ was 63 and all boys were serving sentences for such offenses as truancy, larceny, arson, and running away.
Peins stated the purpose of the therapy program as enabling the boys to obtain optimum communicative effectiveness by which feelings of frustration and resulting behavior would decrease. The specific aims used to accomplish this included establishing rapport and a communicative relationship, stimulating and encouraging spontaneous speech in communication-centered situations, improving vocabulary and speech skills, and reinforcing speech behaviors by means of conversation, discussion, and reality role playing.

The boys received speech therapy and individual therapy at the Robert Wood Johnson Speech and Hearing Clinic at Middlesex Rehabilitation Hospital in North Brunswick, New Jersey. They received 45 minute sessions weekly. The length of therapy varied from one to 19 months. In the therapeutic relationship, the clinician defined their relationship, explained the purpose of the weekly therapy session, and set certain limits to the therapy situation. Although a few boys attempted to test the limits set at the outset of therapy, all of the boys learned to accept and adjust to the therapy relationship.

Peins went into a very detailed account of speech therapy techniques utilized with the boys and illustrated its effectiveness via two case studies. However, in this study there was no objective measure of emotional adjustment nor was there any attempt to objectively support any
behavioral or attitudinal change that may have occurred through therapy. Peins did conclude by saying that there were observable speech improvements but did not qualify her statement. It would seem appropriate and hopefully beneficial to continue this approach to therapy in a controlled situation in order to determine the effectiveness of client-centered communication therapy.

Davidson (1975) completed a four year study at a special education school for English speaking mentally retarded in Paris, France. In this study, she sought to illustrate that mentally retarded children, just like children without mental handicaps, are unique human beings and can respond to psychotherapy, solving problems, and improving emotional adjustment through treatment.

Of the 23 pupils enrolled in the school from 1969, 12 were assigned to regular therapy sessions. The children were evaluated over a three week period. Psychological tests were administered; however, the Rorschach is the only test mentioned by name in the study.

The therapeutic technique primarily used was play therapy, with the use of literal reflections. Davidson felt that the self-image is strengthened through the use of literal reflections. For more verbally fluent children, active role playing was often involved to work through aggressive feelings the children might be experiencing.
The counselor also maintained a protective and encouraging environment to facilitate the development of a trusting relationship. Davidson indicated that these mentally retarded children carried such overwhelming feelings of inadequacy that they were unable to release them on their own. The therapist, verbalizing the feelings and actions of the client, acted as an extension of the child, enabling the problems to be uncovered and then worked through. Ms. Davidson illustrated her therapy technique and its results through three case studies; these, however, were the only results mentioned. No results or further mention of the other nine children in treatment group or the 11 children not in therapy was made. This leads one to question the validity of such a study and the effectiveness of the therapeutic procedures.

Thorne (1948) was one of the first to systematically study the effects of counseling with the mentally retarded. Three hundred and eighty five children at Brandon State School received counseling from January 1945 until December 1946. Two hundred and eight of the subjects were girls; 177 were boys. The results of this study showed that 26 of the girls and 19 of the boys were improved after therapy, eight for both groups were unchanged and four and three respectively were worse.
The method of counseling involved accepting the mentally retarded individual as being a worthy human being, permitting expression and clarification of emotional reactions, patiently teaching methods for resisting frustrations and achieving emotional control, outlining standards for acceptable conduct within the ability of the individual child, building up self-confidence and respect by providing experiences of success and training each child to seek help intelligently through counseling when faced with insurmountable problems.

Though the method of counseling was clearly defined, Thorne made no mention in his study as to how the measurements of emotional adjustment were obtained. There also was no mention of the ages of the children or the presence or absence of any psychopathological symptoms.

A clear example of a biased study is illustrated in Heiser's (1954) study of the results of psychotherapy in a private school for mentally retarded children. Fourteen children with a mean intelligence quotient of 67 were involved in individual therapy for a total of 34 hours each. Twelve of these children were rated as improved following therapy. However, no definition or description of the psychotherapeutic techniques used were given.
Heiser stated that the clients were selected for therapy on the basis of their need and the prospects for their improvement as judged by the examining psychologists and psychiatrists. Also, the other criteria used for selection included the etiology of the children's emotional disorder and the parents' ability to pay a special fee for the therapy. With these confounding variables considered, the importance of the high success rate and the validity of the entire study is in question.

**Group Counseling**

The majority of studies referring to counseling efforts used with the mentally retarded use group counseling techniques. This may be due in part to the fact that in a realistic situation group therapy is more economical in terms of time and in providing services for a larger number of clients simultaneously and with typically limited numbers of professional staff.

Bevan (1960) developed a group counseling technique which combined work therapy with "activity group therapy". He cited clarification or reflection of attitudes as the key to the technique of nondirective activity therapy with the mentally retarded. This technique involved the therapist reflecting the statements and feelings of the client and refraining from making suggestions or interpretations. In reflecting attitudes, Bevan felt that emotions
were released, lowering defenses and permitting more realistic self-appreciation and self-understanding.

To illustrate the differences in the approach to group therapy, Slivkin and Bernstein (1970), who were also involved in an activity oriented group therapy, felt that the group techniques should be highly directive, involving activity, reality reinforcing, clearly defined limit-setting, and active teaching on the part of the therapist. The goal of therapy was to discharge emotions through anger, rage, disgust, and quarreling. Because of the retardate's inability to express themselves verbally, Slivkin and Berstein felt that an acting-out of the group's feelings was required.

Ricker, Pirkard, Gilmore and Williams (1967) have recommended the use of group counseling over individual counseling because it is more economical, efficient, and effective in dealing with mentally retarded clients. Sessions, it was suggested, should be 30 minutes in duration and occur four to five times a week over a period of at least eight months for the treatment effects to have time to materialize with this slow moving population. It was also advised that counseling groups be fairly homogenous and have approximately seven members. A directive and nonverbal approach should be used for groups of aggressive, impulsive clients with limited verbal facility,
whereas a semi-directive or nondirective approach has been recommended for groups of shy, withdrawn clients with relatively good verbal skills.

Following some of their own recommendations, Ricker et al ran a study on group counseling using motion pictures as feedback. The purpose of their project was to develop and evaluate a new method of improving the poor social-emotional maturity and poor social skills of retarded adolescents and young adults via the use of group counseling and audiovisual feedback of the clients own social behavior. Twenty eight percent were emotionally disturbed.

Specifically, the research compared three variations of semi-directive and non-interpretive group counseling with small groups of five to seven adolescents and young adults. The groups were matched on age, sex, IQ, and talkativeness. The experimental group saw sound motion pictures of their own social behavior as a regular part of group counseling. The second group saw a series of films of other retarded people in social situations as a part of their group counseling procedure. The final group received counseling, but did not view any films. It should be noted here that a no treatment control group was not used in this study.

Each group was filmed in social situations (group discussion, luncheon, recreation, and work) each week, but only the first groups saw its own film. An independent
research team from another state viewed these films and rated each client's behavior to measure changes in social skills and emotional adjustment.

Group sessions were scheduled four days per week for four months preceded by a month spent evaluating each client using an extensive battery of tests and followed by a month of re-evaluations to measure any changes in social or emotional behavior. This study was replicated three times rotating the group counselors each time to balance out group leader effects. Follow-up studies were done on all clients seven to 24 months after the termination of the study. Each client averaged 26 hours in therapy.

The researchers predicted that the clients given the audio-visual feedback treatment would show the greatest improvement in social-emotional maturity. This hypothesis was not supported, since all three groups evidenced similar improvement. The authors concluded that the use of audio-visual feedback of the clients' behavior was not worth the added expense.

It is possible that Ricker et al did not obtain positive results because of the limited amount of contact. In their recommendations for group counseling, a time span of eight months was suggested, yet they only maintained therapy for four months. The authors suggested that they might have needed more structure in the therapy, adding
that the heterogeneity of the groups may have facilitated the negative results. Ironically, at the beginning of their study Ricker stated that the groups were indeed homogenous, matched on such variables as age, IQ, sex and talkitiveness.

On the positive side, this study attempted recordable and repeatable objective measures of change unlike many similar studies. The test battery consisted of 13 different tests including the WAIS, Draw-A-Person test, the Vineland, and other projective tests and rating scales. All data was reported along with a description of the group counseling procedure both in formal and informal situations. Also, the results did demonstrate all groups showing positive improvement. Here is where they needed the no treatment control group to illustrate whether or not treatment was effective by comparing their results with those who did not receive any therapy.

Rotman and Golburgh (1967) found that group counseling with mildly retarded adolescents led to a reduction of acting out behavior and a more realistic self-appraisal and self-acceptance on the part of the individuals involved. They worked with three groups of mentally retarded subjects with eight in each group. Two groups contained boys and one group consisted of girls. The ages ranged from 15 to 23. All clients had behavioral problems. It should be noted that no control group was used in this study either,
raising a question of the validity of the results.

Each of the three groups met twice weekly for one hour. Sixty seven sessions were run over an eight month period. Rotman and Golburgh felt that group approaches to counseling afforded the opportunity of setting where the retarded individual might exhibit examples of his inner conflicts and problems which the therapist could observe and evaluate without having to resort to verbal formulations of these problems.

All three groups improved over the course of therapy. However, no explanations were made as to how the subjects were evaluated or as to what specific techniques were used during therapy. This, and the fact that no control group was employed, indicates that the study may be of little practical value to other researchers.

In many of the studies reviewed, there was no control group used. Most studies did not attempt to explain why this was so. Another study which failed to use a control group was run by Miezo (1967).

The subjects were from a private institution for the mentally retarded, and the Child and Adolescent Unit of the Winnbago State Hospital. The children had been in institutions for periods varying from a few months to 10 years. All had been diagnosed as being severely emotionally disturbed. All subjects for group therapy met the following criteria: poor institutional adjustment,
predominantly neurotic rather than psychotic symptoms, retained verbal communicative abilities, and an IQ between 50 and 70. In the final total of 17 patients involved in the study, three were in their 20's, the remainder were in the 12 to 19 age range.

Miezo outlined the basic objectives of the counseling program as: accepting patient as a worthy individual, permitting expression and clarification of emotional reactions, teaching the client methods to resist frustration and achieve emotional control, outlining acceptable conduct standards for each patient, enhancing self-control, outlining acceptable conduct standards for each individual, enhancing self-confidence by providing experiences of success, and training each person to seek help intelligently through counseling.

The subjects were divided into three groups ranging from four to six in size. Attendance was mandatory. Therapy was held in a small office which was simply furnished. Each session lasted 45 minutes. At the first meeting, subjects were told not to discuss meetings with other patients or staff; they were expected to attend meetings on time; and they could talk about anything but were expected to bring up problems or worries concerning their institutional adjustment, their families, or themselves.
After 18 months 15 of the 17 patients were still in the groups. Mild to moderate improvement was exhibited by 12 of the remaining 15 subjects as determined by improved appearance and expressions of well-being, better institutional adjustment, and better classroom and work performance.

In this study all measures of emotional disturbance and post therapy improvement were made by subjective observations. It is felt that the quality and validity of the study would have been improved if more objective methods of measurements were used and had there been some attempt at creating a control comparison condition or group.

There have been many references in the literature concerning the use of operant techniques but few involving the use of it in group therapy. In an interesting study by Schofield and Wong (1975), the authors sought to improve task-attention and socialization of four children with cerebral palsy and/or mental retardation.

The hypotheses for this study were that as a result of treatment there would be an increase in the percentage of on-task behavior within the therapy setting, an increase in social interaction in the group, and an increase in appropriate behaviors and a decrease in maladjustive behaviors displayed by the children,
In the group of four boys, one was mildly retarded, with an IQ of 58; the other three boys had intelligence quotients of 81, 92 and 107. Another group of six children was used as a control group; their IQ's also ranged from average to mildly retarded. Both groups averaged approximately five years of age.

The group sessions were conducted in a small room which contained no furniture except a table and five chairs. The children were seen twice weekly for 30 minute sessions. There were 23 treatment sessions, two pre-treatment sessions, and two post-treatment. No follow-up studies were conducted.

Therapy consisted primarily of guiding the children through structured activities and rewarding individuals and the group as a whole for their progress. During therapy, the mild mentally retarded boy showed improvement in areas of attention span, socialization, and emotional adjustment. These measurements were made via an independent observer.

One major criticism to be made concerning Schofield and Wong's study concerns the method of leadership in the groups. During the 23 treatment sessions, group leadership was juggled between six different individuals. Two of the therapists were the authors, the others were a teacher, an aide, and two undergraduate psychology students. The qualifications of some of these "therapists" are in question.
Even though the study obtained largely positive results, this repeated changing of therapists, which is considered a position of strength and security, could have detrimental effects upon the outcome of the therapy. It is also doubtful that comparing the treatment group to the control group is valid, since the control group never even met as a group, thus introducing another variable into the study.

The following study (Baker, 1972) compares the progress of 25 retarded children who attended an experimental summer camp, based on a matched group of 15 retarded children who did not attend camp. Camp Freedom was established to provide a total therapeutic setting in which a combination of therapy techniques could be employed to help retarded children cope with their deficiencies and subsequent behavioral and emotional problems.

The 45 campers, ages six through 15 were moderately or mildly retarded (children tested average IQ of 53), and many were considered emotionally disturbed. The camp had an interdisciplinary professional staff as well as 13 counselors who were advanced undergraduate or graduate students.

The staff attempted to gear demands to the functioning level of the child, to maximize success, and to increase feelings of self-worth. A warm and accepting environment was maintained as well as a token economy to motivate campers and encourage change.
For this study, 25 campers were selected to be the treatment group and a control group of 15 was chosen. A six item test battery was administered as a pre and post treatment measure. Following the testing, three to five target areas were designated for each child. Examples of target areas included temper tantrums, bedwetting, self-confidence, withdrawal, talking to self, working independently and fighting.

The results indicated that all subjects in the experimental group improved in their target areas. On an arbitrary scale of -1 (worse), 0 (same), or +1, +2, +3 (improved), the median change score for the campers was +1.42, while the median change score for the control group was +0.33.

In this study, Baker chose to measure change that occurred by a subjective rating scale; he did not explain who rated the campers or how the scores were determined. Subjective measurements of behaviors and especially attitudes are always subject to question in terms of their validity. The greatest question posed by Baker's study concerns his report of the subjects' IQ's. In reporting the mean IQ's of the groups, Baker stated that ten or 1/4 of all subjects, were untestable on the PPVT though no other explanation was given. The scores, or lack of them, for these ten subjects should have been dropped, but instead, Baker chose to "reward" them an arbitrary score of zero,
and then he averaged these ten scores of zero in with the test scores of the other 30 subjects. This action lowered the reported IQ mean of his study from 53.1 to 39.8. Although the IQ's did not effect the procedure or results of this study, it is still questionable as to why such a calculation was done. Since many of these children were described as emotionally disturbed and severe behavior problems, their being untestable probably reflected this affective sphere not necessarily their intellectual one. Thus, assigning them with inaccurate spuriously low IQ's is not justified.

Not all studies report as great of a rate of success in group therapy as Baker (1973) did. Zisfein and Rosen (1974) studied the effects of a personal adjustment training group counseling program on 19 mild and borderline mentally retarded individuals. Six other participants formed a no-treatment control group. All subjects in this study were chosen from a community preparation program at Elwyn Institute.

The authors combined a group dynamic approach with behavioral techniques, with the therapist playing a dual role as teacher-model and group leader. The personal adjustment training program was structured around four general goals. The primary goal focused on the improvement of the level of self-esteem, achievement of realistic goals in life, and the development of a more acute
awareness of the self as a social stimulus. The other goals in the program emphasized the reduction of submissive behaviors and dependency with the learning of assertive responses and the learning of self-initiated problem solving behavior.

All members of the treatment and control groups were evaluated using a set of scales and behavioral measures as pre and post test measurements. The treatment groups were evolved in a 12 week counseling situation. The three therapists closely followed counseling guidelines specified in a personal adjustment training manual which will be discussed later in this paper (see Appendix).

The measures used in evaluating the clients included self-evaluation on a 21 bi-polar adjective checklist, client rated sociometric ratings, videotapes, a series of hypothetical questions, and three separate behavioral measures of acquiescence.

After 12 weeks of therapy, objective measurements failed to demonstrate greater change in persons receiving personal adjustment training than in the persons in the control group. It is possible that the measures employed were either too insensitive or unreliable to record if change did occur.

Even though the study failed to show significant improvement in the treatment groups, a positive "trend"
was indicated in the behavioral measures used. In spite of the fact that there was no statistical significance in the results, the study did report all pertinent information involving methods, procedures, data, and subject background.

In an alternative approach to group therapy, Ellis (1976) used group art therapy combined with music and dance to deal with mentally retarded girls ages six through nine with emotional and behavioral problems. Ellis defined her goals of therapy as developing "ego skills" and self-mastery; although these and other terms were not defined further, she hypothesized that through the use of sensory training, group responses to music through dancing, and group showers; the children would develop a greater awareness of their bodies and therefore their selves.

Ms. Ellis did not attempt any objective measures of behaviors, nor any specific report of data; however, she did show through case illustrations the apparent improvement of three different girls. Without any control group or definite procedures, it is unsure whether it was the sensory training and art therapy that caused the children's behavior to improve or whether it was the warm and accepting environment which she created that fostered individual growth.
Albini and Dinitz (1965) combined the use of both individual and group therapy in dealing with emotional problems in institutionalized boys between the ages of 7 and 15. There were 37 boys in the experimental group and 36 in the control group; the groups had a midrange IQ of 59. The authors followed a largely nondirective and verbal approach to therapy.

There was no significant difference between the experimental and comparison group on any of the objective measures involved at the end of 48 half-hour sessions, although two of the behavioral measures indicated a trend toward improvement in favor of the treatment group in areas of emotional adjustment. The authors concluded that the results of this investigation indicated that short term therapy with mentally retarded was not the treatment of choice. In fact, the control group in this study showed more positive change in the areas of behavior and attitude than did the experimental group. In conclusion, no details in the Albini and Dinitz study were given of possible reasons that the study failed to produce positive results, other than assuming that short term therapy was not the treatment of choice.
Discussion and Conclusion

It would seem apparent that there is a definite need for mental health professionals in the field of mental retardation. With the high incidence of emotional disturbances in this population, attention must be given to seeing that the mentally retarded in both the community and institutions receive the necessary counseling and psychotherapy that is needed for these individuals to function at an optimum level. Further research in the areas of individual and group counseling and the use of various other theoretical approaches is necessary to help determine which methods are the most effective. As Beier (1964) states:

A majority of articles in the literature report successful results in the use of individual psychotherapy with mental retardates. Quite likely many of the failures remain unreported. The degree of success is moderate and often ill-defined. Most "improvements" in "adjustment" are subjectively determined and frequently ill-defined. Most of the "improvements" noted in the literature refer to personality variables; increases in intellectual levels are still suspect. It appears for successes, however, it seems to be equally clear that more directive and structured approaches are probably more effective with the aggressive acting-out, impulsive, sociopathic, and delinquent varieties of retardates, and the non-directive techniques with the withdrawn, shy, and anxious types. In psychotherapy, with retardates the goals must frequently be modified to fit the retardates potentials, and it is reasonable to predict that new techniques must be developed and combinations
of psychotherapy and techniques of chemical management more thoroughly investigated. The use of now existing psychometric devices as instruments for evaluating the effects of psychotherapy suggests only cautious optimism for definitive results. A majority of such devices are either too insensitive or too subject to interpreter biases, within their current systems of scoring, to permit conclusions being made from their use with any reassuring degree of confidence (p. 476).

In the studies reviewed in this paper that dealt with individual counseling or psychotherapy, all reported positive results. However, three of the five studies offered no object report of data (Hellinger, 1963; Peins, 1967; and Davidson, 1975). Hellinger, Peins and Thorn (1948) did not use a control group in their respective studies, and in Heiser's (1954) report, the counseling techniques used in the therapy sessions were not specified.

In all studies where the techniques were specified, the humanistic approach was used either alone or in conjunction with other techniques. Hellinger's approach was eclectic. Peins stated that while her study was structured, a warm and accepting environment was necessary. Although Davidson described her study as psychoanalytic, there were strong humanistic overtones present. Thorn clearly stated that his approach was humanistic.

While the studies on group therapy did not report the frequency of successes that those dealing with individual did, this approach appears to be more practical and more
objectively reported. Out of the seven studies reviewing group therapy efforts, only Miezo (1967), Rotman and Golburgh (1967) and Ricker et al (1967) failed to employ a control group. Rotman and Golburgh were also the only authors who did not specify what counseling techniques were used in their study.

The techniques used in these studies varied. Ricker et al presented a semi-directive and non-interpretive approach. Miezo, Ellis (1976), and Albini and Dinity (1965) used non-directive techniques. Schofield and Wong (1975) report a combination of a directive and a behavioral approach. Eclectic methods were employed by Baker (1974) and Zisfein and Rosen (1974).

While the majority of studies showed positive results, Zisfein, Rosen and Albini, and Dinity failed to find any significant differences between their respective control and experimental groups. In the report by Ricker et al, no differences in the three experimental groups were shown, although all three groups did evidence general improvement.

A better understanding of emotional difficulties is needed so that we may plan for services that will help the mentally retarded achieve optimal adaptation. As community resources are developed fewer people will need to be institutionalized (Freeman, 1970).
Many of the mentally retarded who suffer from emotional disturbances have been inaccurately or only partially diagnosed. According to Loschen (1975), an accurate and skillful diagnosis is mandatory for an adequate and comprehensive treatment-management plan to be formulated for the retarded. Errors in diagnosis often result in emotionally disturbed mentally retarded not receiving the psychiatric care that is needed in conjunction with community and institutional retardation programs.

The results of the studies reviewed and the practical application of therapy with the mentally retarded would support the use of group counseling because of the advantage that it allows one counselor to serve many clients simultaneously. It is felt that group counseling also creates an atmosphere in which both peer support and pressure, and the presence of a parental authority figure, support a climate for change as well as developing social skills necessary for independent functioning in the community.

In regard to theoretical approaches, it seems that the eclectic approach would be the most successful. In this way the therapist would have flexibility necessary in dealing with emotionally disturbed mentally retarded and at the same time be able to call upon the strengths of a variety of theoretical frameworks.
Recommendations

There are still many questions to be answered in the area of the relationship between mental retardation and emotional disturbance. The following is a list of suggestions for future research and development in this challenging relatively unexplored field:

1. Further evaluation of current treatment-management approaches as to what techniques are successful are direly needed.

2. The majority of the literature reviewed concerns institutionalized mentally retarded and emotionally disturbed individuals; more research into community needs and resources is necessary.

3. More information is needed on the relative impact of early intervention on both mental retardation and emotional disturbance.

4. More direct observational data on the attitudes, feelings, and experiences of the retarded is needed to help determine why some retarded individuals experience emotional disturbances while other similar individuals do not.

5. More information is needed on the developmental and experiential influences on the development of emotional disturbance in the mentally retarded.
6. More information is needed for diagnosing the "chicken and egg" problem, is the client mentally retarded with emotional disorders, or is the client emotionally disturbed with subsequent deficits in intellectual functioning, and does this make a difference as to what course of treatment would be followed?

**Summary**

In this review of the literature, the psychological problems and their symptoms that occur in the mentally retarded were investigated. It also sought to determine whether or not psychotherapy and counseling are effective methods for dealing with emotional disturbed mentally retarded individuals.

The incidence of emotional problems occurring in the mentally retarded population was investigated finding studies which reported frequencies varying between 40 and 87 percent overall. Institutionalized retarded individuals exhibited a higher frequency of emotional disorders than did those retarded studied in the community.

The various characteristics of mental disorders and their likelihood of occurrence were reviewed. Mentally retarded individuals were found to be especially sensitive to transient situational disturbances followed by neuroses and psychoses.
Factors associated with the development of emotional disturbances in the mentally retarded showed that social status, physical normality, and adverse psychological conditions at home are areas of concern.

The various therapy techniques used in treating emotionally disturbed mentally retarded individuals were discussed, comparing the effectiveness of individual and group approaches as well as directive or non-directive methods.

It was concluded that in dealing with the mentally retarded, an eclectic approach to therapy would be the most appropriate because of the need for flexibility in working with mentally retarded people. Also, because of the practical aspect of group therapy providing services for more clients, this form of therapy was determined to be preferable. Finally, it was recommended that further research be done in the areas concerning the development of emotional disturbance in the mentally retarded and what techniques would be most effectively used in therapy.
Appendix

On the next page is an abbreviated version of the Elwyn Institute personal adjustment training manual for group counseling with the mentally retarded (Rosen and Hoffman, 1975).

Further information on treating emotional problems of the retarded and home counseling techniques can be found in other procedural manuals from Elwyn Institute (Rosen and Peet, 1975; Rosen and Phillips, 1975). These manuals are applicable to emotionally disturbed physically and mentally handicapped.
<table>
<thead>
<tr>
<th>Unit#</th>
<th>Title</th>
<th>Purpose</th>
<th>Techniques</th>
<th>#Sessions Required</th>
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<tr>
<td></td>
<td>Initial Orientation</td>
<td>Orientation in the concept &amp; terminology of ABT</td>
<td>Identification and labeling of behavior</td>
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<td>1</td>
<td>Social Image</td>
<td>To promote awareness of oneself as a social organism.</td>
<td>Modeling, labeling, 3 videotape recordings and playback</td>
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<tr>
<td></td>
<td></td>
<td>To teach codes of appropriate dress and physical mannerism.</td>
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<td>2</td>
<td>Speech</td>
<td>To improve quality and content of speech</td>
<td>Modeling, labeling, 1 role-playing</td>
<td></td>
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<tr>
<td>3</td>
<td>Social interaction</td>
<td>To teach clients to act in regard to situational cues and social expectations</td>
<td>Modeling, labeling, 5 role-playing social situations</td>
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<tr>
<td>4</td>
<td>Expression of anger</td>
<td>To teach clients to express feelings of anger and hostility in an appropriate manner</td>
<td>Modeling, labeling, 1 role-playing social situations, group discussion</td>
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<tr>
<td>Unit#</td>
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<tr>
<td>5</td>
<td>Sexual behavior</td>
<td>To impose a structure upon the exhibition of self-stimulating behavior.</td>
<td>Modeling, labeling, role-playing social situations, group discussion</td>
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<tr>
<td></td>
<td></td>
<td>To teach clients to differentiate behavior according to locale and situation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recapitulation</td>
<td>To integrate and review previous units; to demonstrate gains by students</td>
<td>Identification, labeling, group discussion</td>
<td></td>
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</tr>
</tbody>
</table>
In the state of Florida, mental retardation is categorized in terms of educable, trainable and profound for the purpose of state funding of the educational systems.
Bibliography


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