

THE CASE FOR COMPREHENSIVE TRAINING

H. C. GUNZBURG, M.A., Ph.D., F.B.Ps.S.

Monyhull Hospital, Birmingham.

In recent years there has been quite a remarkable change of emphasis from custodial to rehabilitative training. The work carried out at hospitals in connection with these new ideas has naturally enough concentrated on the needs of the less severely handicapped — in the old phraseology, the feeble-minded patient. Since in his case the intelligence level was sufficiently high to enable him to carry out some useful work, the problem was very often not so much whether he was able to do a job as whether he was able to retain a job. It had been shown again and again that the subnormal's success or failure in the open work situation was very often not the result of a high or low intelligence level but of an inability to put to effective use the limited, but usually adequate, intellectual capital in his possession.

This low functioning in the presence of a higher potential has generally been ascribed to the disturbing effect of personality factors in conjunction with adverse environmental circumstances.

It seems a logical next step to overcome the consequences of this unfavourable combination by devoting particular care and attention to those aspects which can be dealt with by the means at our disposal. This has been done with some measure of success in the case of the feeble-minded patient, and the question arises whether similar considerations would also validly apply to the case of the severely handicapped, the imbecile.

Environment:

Environmental circumstances, responsible for instability and social inefficiency, appear to be the easiest and most obvious aspect that can be tackled. In practice this has always resulted in a half-measure: removal from a disturbing adverse environment to the more settled, supportive environment of the hospital. In many cases this change of environment is in fact all that is required, in others it leads to the dreaded "institutionalisation." However the fact that a change of environment can result in an unhappy outcome, if limited to unimaginative, unstimulating hospital residence, does not mean that "hospitalisation" is a bad thing in itself. It is obviously a form of treatment, which, in the right hands, can be of great help, because firstly many difficulties of adjustment can be overcome by learning to live and work together in the hospital community, and secondly because it is frequently impossible and impracticable to give adequate individual help to everyone at all times.

Hospitalisation of the severely subnormal is, in fact, more than acceptable to those parents who have actually tried it out. A recent survey (Tizard and Grad 1961) showed that four-fifths of the parents expressed satisfaction with the care and training and praised the work done. Yet, there is much evidence that institution training is one-sided and unimaginative and fails quite markedly in certain respects. The same report suggests that in a good many subnormals "social competence has decreased after admission to an institution" and in others it had not increased. A comparison of the social accomplishments of imbecile children brought up at home with those living in institutions indicated that the institution children were much inferior in tasks well within their abilities. This is of course nothing new (Lyle 1959, 1960; Sievers and Essa 1961). Institutionalised imbeciles tend to be more

severely handicapped than those kept at home, and the overcrowding of the wards, lack of qualified staff and inadequate provisions help a good deal to explain the "backwardness" of the institutional child. Yet, another remark in the above-mentioned report makes one wonder whether this is the full explanation. Tizard and Grad state: "The data suggested that the institutional defectives were less retarded in such skills as dressing, or eating at table, which contributed to ease of management, than in speech, or in constructive methods of amusement, which had no such function." In other words, skills which served the immediate purpose of "institutional life" were developed either by formal training or by offering ample opportunities for incidental learning, but skills referring to "outside" and to the future, fail to develop.

The tradition of the "Colony"—the self-sufficient institution—where patients were trained for a life "inside" will take some time to die out, but it is important to remember that the disadvantages of "institutionalisation" are not entirely inherent in the system. They are a consequence of stubbornly maintained ideas and beliefs regarding the type of patient who is institutionalised, his limitations and his unpromising future, with a consequent crippling effect on anything exceeding the requirements of "care and supervision." It has recently been shown (Lyle 1960) that even an institutional environment where adequate arrangements were made can assist considerably in developing verbal expression, verbal understanding and social efficiency.

Using the institution as a therapeutic agent rather than as a place of residence, requires however a rethinking of the training programme and a reconsideration of the patient's abilities and potentialities.

Personality Factors

It is scarcely an exaggeration to say that the presence of a "personality" in the subnormal is a discovery of recent date. The subnormal has been and still is being considered as a **cognitive deficiency**, expressed in IQ terms and "understood" by reference to Mental Age. In consequence the individualised psychotherapeutic approaches developed for maladjusted children and adults with personality disturbances were neglected, though behaviour problems within the restrictive institution environment were frequent and disturbing.

The intelligence test result provided an easily obtained "explanation" for social inefficiency and much lack of endeavour can be attributed to the misuse of the intelligence test. It stifled the development of a training programme designed to serve more than the immediate needs, and discouraged further trials after initial failure.

The exaggerated value given to the possession of a "normal" IQ and the consequent fatalistic prognosis given to the "low" IQ are ideas still much in evidence. There has been a startled realisation that there are many decent people about, who have never required assistance despite their IQ being below normal, yet it is still not quite realised how far down the IQ scale one can go before somebody is completely inefficient. It has been estimated (Tizard 1958) that between 10 and 20 per cent of imbecile adults are gainfully employed in the community and this figure may even be conservative.

A small and not at all representative survey of patients at this hospital showed that on a given day 29% of the patients gainfully employed outside the hospital were classified as imbeciles. A follow up of 15 patients with IQs below 50 (Mean IQ 43) indicated that their wages—obtained in ordinary working conditions—ranged from £4 - 10 - 0 to £9 - 0 - 0.

Whilst figures obtained from ad hoc surveys cannot give an idea about the extent of rehabilitation possible in the lower IQ range they certainly suggest that a low IQ need not be a barrier to rehabilitation.

From time to time provocative cases are reported in the literature which indicate that the prediction based on a low IQ, while generally reliable, can be most misleading, if exceptional training facilities are provided. Only recently a report was published on a Mongol with a MA 5 and IQ 28, who obtained a Social Age of 11 on the Vineland Social Maturity Scale. He was able to do habitually tasks which were placed on the 12 to 15 year level (performing responsible routine chores) and he was able to care for self and others at the 11 to 12 year level (Butterfield 1961).

It is like trailing an over-ripe herring if one mentions once again the changes in IQs which in recent years have been demonstrated by various research workers (Clarke and Clarke 1954, Walton and Begg 1957, Clarke and Clarke 1958, Hermelin and O'Connor 1960). Yet traditions and prejudices die hard and it is important to emphasise again the fact that a young severely handicapped adult may be capable of responding even to academic training after the age of 16. The maturation process may still be going on and he may therefore require as much attention and stimulation in his adolescence as when he was still at school. There can be no justification for limiting training to one-sided instruction — such as workshop training — on the grounds that intellectual development has ceased.

The use of intelligence tests has not always helped in the actual task of rehabilitation and treatment. They have been and still are mainly used as classifying instruments. In many cases the objective intelligence test assessment has been able to point to some unexpected potential in a subnormal who would otherwise have been left to vegetate without special assistance. There are however inherent dangers in using the Intelligence Test as a screening device and many clinicians have been dissatisfied with obtaining simply a figure from omnibus tests of varying composition. They were therefore drawing inferences from observing the behaviour of the person tested and their report on the "quality" of intelligence, contrasted with the quantity of intelligence as represented by the M.A. and IQ, pointed the way even though these interpretations have been at times very intuitive and rested on facts, arbitrarily chosen for their supposed significance.

The various studies referring to classifying patients according to brain injury have not been very convincing and still fail to obtain results which can be used directly in rehabilitative work. It appears most important that the psychological contribution should not be limited to developing still more tests for classifying by giving an overall assessment of abilities (which clouds the important differences between assets and deficits) but should be concerned with constructing diagnostic instruments which would point the way for rehabilitative measures. Something on these lines has been developed recently (Kirk and McCarthy 1961) in the Illinois Test of Psycholinguistic abilities which measures specific abilities and leads directly "to a program of remediation and treatment which will utilize the child's assets to develop the areas in which he is deficient."

It must be pointed out that designers of intelligence tests have always emphasised that intelligence cannot exist by itself in a vacuum. Other factors like persistence, desire to succeed, curiosity, impulsiveness, need for praise, etc., play as great a part in the test performance as in real life, and their influence on the final intelligence scores must not be overlooked. It is disheartening to see how little has been done to appraise the influence of these factors. Personality and temperament — rather vague concepts which defied measurement — have been omitted from the textbook literature on mental deficiency and it is only this year that we have seen the first original treatise on the "subnormal Personality" (Earl 1961).

Certain typologies were, it is true, carried forward from one generation of workers to the next. Tredgold described the overactive, excitable and unstable subnormal, and contrasted him with the harmless, inoffensive, stolid and well-behaved subnormal. The first one, it is said, cannot be employed in any kind of work, whilst the other one is tolerably industrious within the limits of his capacity. There was also a traditional belief of the docility and pleasantness of the mongol — a myth which has been destroyed by recent research (Rollin 1946, Tizard and Grad 1961, Blacketer-Simmonds 1953). Such personality descriptions have been feeble and added little or nothing to our understanding of the subnormal nor to the problems of his management and training. Recent research has suggested that personality make-up may have quite marked influence on the subnormal's learning and work performance. It was shown that the excitable imbecile required more encouragement and incentives to perform well than his more inert colleague who carried on quite steadily. The excitable also declined quite rapidly in efficiency once the incentive was removed, whilst the inert imbecile carried steadily on (Claridge and O'Connor 1957, Claridge 1959). Findings of such a nature agree substantially with much of modern learning theory and indicate a close relationship with personality factors as found in normal subjects. They also help to explain the failure to predict differences in improvement after training on the basis of tested intelligence and suggest that there are other possibilities of influencing the subnormal than have been used so far.

The reward and incentive system, which could be an extremely useful factor in motivating the subnormal, is usually rather ineffective and handled without imagination. Whilst one can see that using monetary incentives provides, administratively seen, the most efficient system of recognition of work achievements and is also the most realistic method of reward, it is doubtful that money is always a motivating factor. Appreciation of money values may decline quite considerably further down the intelligence scale and other means will have to be found to motivate the patient. In this connection one is reminded of research work some thirty years ago (Aldrich 1931) when it was shown that very severely handicapped patients became really active and even inventive under strong stimulation though they showed less interest and little efficiency in ordinary reward conditions. In that particular case the rewards were of a concrete nature, a ball, a sweet, a cookie, but glimpses of constructive thought were shown only when a coveted banana was offered. We may well have to study the individual patients' likes and dislikes far more carefully to evolve an individual system of incentives. The importance of finding suitable means for stimulating and motivating the subnormal to overcome the present understimulation, particularly in institution environment, cannot be overstressed. Research work in this country (Clarke and Clarke 1958) has shown how ordinary incentives, consistently applied, can succeed in attaining a much higher level of work efficiency in the severely handicapped than had been assumed in the past. Even better results might be achieved by adjusting the reward system to the individual's personal preferences.

Training for Living

From what has been said so far, it appears that the two major areas of training and treatment—environment and personality—could do with a re-valuation and a consideration of those aspects which have either been inadequately treated, e.g., motivation, or have been approached from a different and by now rather obsolete viewpoint, e.g., institution environment. This appears even more important now when the work of caring for and training of the subnormal will be carried out very often outside the hospital wards. One may well ask whether the major and most significant difference between treatment in hospital and treatment carried out in other places, e.g., sheltered workshop, is simply one of residential versus non-residential treatment; whether it is avoidance of hospitalisation rather than a different

form of treatment which decides disposal; whether the methods of hospital treatment (minus conditions of residence) could and should be "exported" into the "industrial centre," etc.

During the last ten years or so, there developed in the hospitals for the subnormal a distinct fashion, called "industrial training." The most characteristic feature of this development was the fact that "work" for the patients was obtained from outside the hospital and that the work performed by the patients was therefore no longer predominantly in the service of the "Colony." The "industrial training" has many outstanding advantages, which are by now well-known and need not be reiterated here. "Industrial training" of this kind has been adopted without reservation by the industrial centres, adult occupation centres, etc., which have begun to develop outside the hospitals, and "work" has been made the royal road to treatment.

It is interesting to note that "work" is the only aspect of training which was introduced right at the beginning of Mental Deficiency Care and which survived the transition from "Colony" (custodial) training to Hospital (rehabilitative) training and has been fully accepted in those centres outside the hospital which deal with the same problems. One must realise that much of what is taking place is not anything new at all. The "Colony" was a place where the "inmates" earned their keep as far as they were able. It was only at a later date that wards began to accumulate crowds of unoccupied and stagnating patients who deteriorated rapidly. This may have been due partly to overcrowding, partly to staff shortage, partly to disappearing enthusiasm and partly to disillusionment. The renaissance of "work" which we behold nowadays is therefore rather a re-discovery of standards and ideas which have been forgotten in the same way as the Romans' civilised ideas of bathing, hygiene and duct heating were forgotten in the "Dark Ages."

The real difference between the "work" as practised in the past and the "work" as it should be conceived for the future, is not the difference between brush- and mat-making on one side and industrial assembly work on the other side. The difference is found in the purpose of the work training. In the first case, the training and occupation was for the life "inside" the "Colony" or even the Hospital, whilst in the second case it should point to "outside." Whilst it is conceivable that "work" was the main if not the sole target of training in the limited and narrowly circumscribed and regulated world of the "Colony," it seems an inescapable conclusion that in the wider world outside the institution walls, "work" must take the same relative place of importance in the life of the subnormal as in the life of any other free "normal" man. Whilst in the restricted cloistered institution life, which provides a permanent custodial shelter, "work" appears to be an "end" in itself, it must become a "means" to an end in the case of those who do not require custodial supervision.

One has nowadays often the impression that in the newly awakened enthusiasm for "industrial work" the fundamental difference between "ends" and "means" is often overlooked. In consequence "work," even if it consists of industrial assembly work, is nothing more than a fashionable way of occupying the subnormal. The fact that proper wages are paid, that people clock in and out, that they work at benches with machines and tools and do work of commercial value is of relatively little value if the end result is simply work of a different character and of more eye-appeal. It appears to be rather shortsighted if it is thought that working and living in the community requires in most cases nothing more than simply an ability to sit at a work bench and produce a reasonable output.

Unless "work" is considered as one of several agents which can help in the socialisation of the severely subnormal, there appears to be no genuine difference

of aim between work carried out in a workshop outside the institution and work carried out in a workshop inside the institution. The difference of geographical location is of no real import.

Once it is decided that "work" by itself can contribute only to a limited extent towards the skills required for living in the open community, attention will have to be paid to other means of training. Education comes to mind as being the most direct way of teaching and training. The formal school education approach seems rather out of place for the young adult. It appears to have some justification considering the mental level of the subnormal adult, but seems to miss the point if one considers the purpose of the educational work. A simple imitation of "normal" schoolwork, suitably adjusted to the low mentality of the adult pupils, will end in an educational cul de sac. Whilst educational work in the normal school with the ordinary child lays the foundations on which further education will be placed, there is, generally, little hope that the subnormal will substantially rise above primitive educational level. It may well be argued that it might not be wise, practical or economical in time and effort to attempt to build educational foundations which will never be used. The laborious teaching of the alphabet to imbeciles may give the impression of school learning and please the parents but it is, in the end, a dead gain, which cannot be used in any social situation. The curricula of educational schemes for adults are full of examples of such useless achievements, which imitate the "subject approach" of the school without any reference to the purpose to which such attainments could be put. Reading, Writing and Arithmetic, to single out the traditional triad, are subjects which are taught as if further developments were expected to take place any day from now onwards. The most that can be achieved is the "cat sat on the mat" stage and perhaps a highly developed skill of making the appropriate sounds to the symbols on a white page — without understanding the meaning of them.

It is possible to conceive the educational work not as a means of laying "sound foundations" but as providing those educational and social skills which help the subnormal to exist without major trouble in the community. Instead of teaching the subjects reading, writing and arithmetic in isolation, it may be better to study an actual life situation. e.g., leisure-time, going off sick, relationship with the landlady, an interview with an employer, and to investigate how much reading, writing and arithmetic are required to solve these particular situations. Relating the type and extent of actual academic instruction to the concrete life situation, may result in limiting "education" to manageable size and will help in providing some "motivation" as the subnormal sees education "at work" as it were and realises where it "comes in." Considering that the mental capacity of the subnormal is limited, that the time and manpower available for teaching him is restricted, this appears to be an eminently practicable approach, which would ensure that something worthwhile and useful is taught at any stage of the educational work.

To sum up: We cannot expect appreciably higher educational attainments in the subnormal, and there appears to be little point in providing the educational tools, mechanics and techniques which a normally developing person can apply flexibly to situations as they develop. Based on the generally valid assumption that most of the social situations which the subnormal will encounter are pretty similar and are limited in number, we must content ourselves with providing the ready-made solution, the limited technique to tackle a particular situation. This type of very limited skill will obviously not suffice to tackle the unusual situation, deviating from the normal everyday routine, and difficulties and disturbances will always arise. Yet, it may be said in support of this type of social learning that it may reduce the number of situations which are trying for the subnormal and it also offers some possibility of softening the impact of these situations by giving the subnormal some measure of self-confidence.

The fact that this approach is applied to the young subnormal **adult** has some advantages. The increased maturity of the subnormal, some life experience and increased motivation may well result in an increased desire to adjust and to acquire that type of knowledge which, as he realises, is of direct benefit to him. By using a different approach than the "subject" teaching practised at school, the "school neurotic" adult with an educational inferiority feeling is often successfully deceived into learning when he might have put up some effective resistance to remedial education.

Education of this kind differs from traditional school education and from modern remedial teaching. It must be conceived as a therapeutic agent — in some cases dealing directly with those subnormals who feel inferior about their illiteracy, in others dealing with a social situation as a whole rather than with techniques and skills from which the appropriate method has to be selected in each individual situation.

One factor which may be of great importance to the learning of how social situations are to be tackled is language. In institutional settings and submarginal cultures, development of language has been much neglected and lack of experience has led to difficulties in communication and resulted in frictions in adjustment (Lyle 1959, 1960, Sievers and Essa 1961). The typical subnormal has great difficulties in expressing himself but this is very often due to lack of cultural opportunities rather than low intelligence. If a determined effort is made to encourage this under-developed skill, it has repercussions on social competence as has been shown in the Brooklands Experiment (Lyle 1960). There, in an institutional, but home-like environment, the verbal abilities of the severely mentally handicapped children improved significantly and also their desire for and ability to mix with other children of the same mental age. The results of an energetic and consistent effort of teaching the mother tongue to the subnormal pupil may well be very striking (Gulliford 1960). Again, this teaching aim could more easily be incorporated in an approach which stresses what to do and what to say in a particular social situation, because it gives opportunity for rehearsing and practising in the form of "socio-drama" rather than in the cramping drill situation of the remedial school teaching.

Rehearsing, practising and discussion of social behaviour by means of the educational situation is introducing a third aspect of training on a very concrete level which will take its place beside "work" and "education." It appears difficult to give it a specific name which means the same to everybody. Psychotherapy appears often too grand a name, because of its association with the psychoanalyst's couch and Counselling is perhaps the preferable term. Its essence is the recognition that the subnormal will, in most cases, require a supportive hand on his shoulder from time to time. Often his own relations, an understanding employer, a sympathetic workmate perform this service — in other cases more skilled help must be made available. Before this situation arises very often much spadework has to be done to show the subnormal how to ask for help and how to accept help. It has now been realised in professional circles that some form of individual therapy can help considerably in overcoming those difficulties when the lines of communication get crossed between the unintelligent individual and the too demanding, and to him incomprehensible, environment. Therapy may in many cases mean no more than rushing along with an oilcan to soothe troubled waters, yet these storms in the teacup may assume dimensions quite out of proportion to the cause, on account of the subnormal's mental limitations. A succession of apparent "wrongs," "unfairness" and humiliating failures may trigger off antisocial activities as a pure defence reaction. A suitably designed work-programme giving confidence in the practical abilities, and a suitably designed educational programme giving confidence in the social abilities, will go more than half-way to meet most of the problems. In some

cases this may well be all that is required, but in others more individual help must be available. It appears that help of such a kind should be an integral part of comprehensive training — not necessarily “laid on” for everyone without discrimination, but available in full measure when and where required. Since both work and education are to be considered therapeutic agents, it may well be that they have to subordinate themselves to the requirements of psychotherapy which is concerned with the human being as a whole rather than the “worker” or the “pupil.”

Conclusions

There is nowadays a very marked tendency to avoid hospital or institutional care and to substitute for this community care of one form or another which avoids residential treatment. It is suggested that this change in form may give an opportunity for developing changes in approach regarding training and rehabilitation. The whole situation needs careful re-examination to make sure that the change does not merely give the appearance of progress but is in fact genuine progress.

The subnormal's problems are manifold: social and personal maladjustment, inadequate work performance, illiteracy, domestic incompetence, temperamental shortcomings, shortsightedness, rigidity in thinking, etc., are only a few aspects which require attention. His deficiencies in a work situation represent only one problem, very often not the most important one, and sometimes it is even quite negligible. Yet there is a marked tendency to concentrate entirely on this one aspect of rehabilitation and to overlook entirely the fact that the subnormal has also to live and get on with his fellow men outside working hours.

Unless the purpose of this type of training — re-socialisation — is kept very firmly in mind, and training in work is made to serve this aim, the result is the sheltered workshop outside the institution, scarcely a step removed from the sheltered workshop inside the institution. If, on the other hand, an attempt is made to tackle the consequences of subnormality on as many specific fronts as possible, the result may be not only a better job in the end, but an unexpected all round improvement, because chords have been touched which would have been missed in the narrow, one-sided approach.

The principle of a comprehensive training approach applies to all levels of subnormality. Methods and actual teaching objects will have to be adjusted — education for the imbecile will be of a different calibre than education for the feeble-minded — yet in both cases the aim will be the same: to make the subnormal as efficient as possible. Some years ago, the writer would have added the phrase “within the limits of his capacity.” One hesitates to add this provision because the association with testing, particularly intelligence testing, is unavoidable in this context. As far as the individual is concerned — and he alone is legitimately the subject of our endeavours — test results have, in most cases, such limited value, that the only logical and ethically correct course is to provide as many opportunities and as many training facilities as possible, irrespective of any ideas we may have acquired regarding the significance of an “intellectual ceiling.” Whilst it would be foolish to deny that there are very real and marked differences between the performances of an imbecile and a feeble-minded person, and that the test result reflects this difference, it is now common experience that predictions on these grounds are often, in the individual case, inadequate and deceptive. There are resources in the subnormal, circumstances in the environment and methods of training which result in unexpected and unexplained development. The rehabilitation programme must aim at these aspects and not be contented with widening the path which has been well trodden by past generations.

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