

SEX AND THE DEVELOPMENTALLY HANDICAPPED ADULT: A COMPARISON OF TEACHING METHODS

PETER R. JOHNSON

University of Calgary, Alberta, Canada *

During the last two decades, concern about the civil rights of minority groups has played a significant part in the development of North American society. In spite of their limitations in self-promoting enterprises, developmentally handicapped people have not been excluded from this movement. The result is that many of them have been released from institutional confinement so they can participate in training programmes which prepare them for independent, community-based living.

Unfortunately, a bias appeared in the development of these programmes. As reviewed by Gold (1976), they seemed to be mainly focussed on the important area of work-skill competence. The topic of interpersonal social skills received much less attention (Perry & Cerrato, 1977; Rosen, Floor & Zisfein, 1975; Zisfein & Rosen, 1973), while the sexuality of these people was largely neglected. The few programmes which were introduced during this period tended to deal with the topic in an arbitrary and unenlightened manner (Abbott & Ladd, 1970; Carruth, 1973; Thorne, 1975). Certainly, systematic training and evaluation were not applied in this area.

The underlying reasons for this lack of sexuality training were probably twofold. As a result of Judaeo-Christian religious teachings, many people still seem to perceive sexuality in a negative context. In addition, the traditional stereotypes of mentally retarded persons, i.e. diseased organisms, loathsome monsters, and eternal children (Wolfensberger, 1972), all precluded their right to be sexual. Consequently, as Johnson (1973) points out, the inhibitions of parents, administrators, teachers and trainers have been largely responsible for the dearth of sexuality training for developmentally handicapped people.

Now we are able to recognise these shortcomings, our knowledge of the principles of learning can be applied to sexuality training, and we can attempt to provide programmes which are practical and meaningful to our trainees. To this end, the present paper attempts to describe and evaluate a group sexuality counselling programme for mentally retarded adults.

Previous sexuality training programmes (AAHPER, 1971; Fischer & Krajeck, 1973; Kempton, 1975; Meyen & Carr, 1967) have been focussed almost exclusively in the trainee's cognitive domain. These information-giving approaches have tended to neglect the affective and psychomotor components of learning and this may be a mistake if one considers being sexual as an integral part of human-ness. Consequently, the present programme attempted to range beyond the narrow confines of "information-giving", and to include the trainees' own experiences, concern, and feelings.

As sexual activities are essentially social in nature, the group counselling approach should produce several potentially positive aids to learning. While there is a lack of objective evidence supporting the use of this technique with retarded people (Gunzburg, 1974), there is no theoretical reason why Yalom's (1975) curative factors should not apply to this population. Yalom, in his group work with normal and psychiatric subjects, noted that factors such as imitation, altruism, universality and social learning were associated with a positive outcome. Consequently, it was hoped that small, interactive groups would provide a mutually-supportive environment in which trainees could explore both the affective and cognitive aspects of sexuality.

* Vancouver-Richmond Association for the Mentally Retarded,
2979 West 41st Avenue, Vancouver, B.C. V6N 3C8.

Nor was the psychomotor component neglected, for behavioural training was also an important item. As Zisfein and Rosen (1974) demonstrated, the small group dynamics approach can be combined with the direct teaching of social skills. Therefore, it was decided that rôle-playing, assertiveness training and systematic de-sensitisation would be an integral part of the course.

The efficiency of group counselling was also considered. As Brown and Dyer (1963) have shown the cognitive benefits of psychomotor exercises, it was thought that the present method of teaching would add increased sexual knowledge to the expected improvements in social behaviour and gender identity.

These deliberations gave rise to the following experimental hypotheses:

- (a) Group sexuality counselling is an effective method of training for mentally retarded adults.
- (b) In comparison with a traditional didactic approach, group sexuality counselling (i) significantly increases subjects' sexual self-images, and (ii) improves their socio-sexual behaviours, while (iii) providing a meaningful base of sexual knowledge.

METHOD

Sexuality Development Index (S.D.I.)

As comprehensive assessments (Gunzburg, 1969; Marlett, 1971) have formed the basis of many successful training programmes (Marlet & Hughson, 1978), it was decided that the project would begin with an assessment of the current status of the subjects. However, due to the previously-mentioned lack of systematic research in the area, it was necessary to create an instrument which measured development in the area of sexuality. Hence the Sexuality Development Index (S.D.I.) was constructed, and this contains three sections which focus respectively upon gender identity, socio-sexual behaviours and sexual knowledge.

Piagetian principles underlie the construction of the test, and its design takes into account intellectual capacities as under-developed as those of the sub-period of Preoperational Thought. This cut-off point, between the Preoperational and Sensorimotor stages of development, was chosen as the earliest time that the individual becomes actively involved in social relationships.

During the construction of the S.D.I., several additional factors were taken into consideration.

- (a) Due to the intellectual limitations ascribed to the sub-period of Preoperational Thought (Flavell, 1963), the test items are presented in a concrete, visual form, by means of a videotape.
- (b) Bearing in mind the desirability of working, as much as possible, within the testee's own conceptual framework, an effort is made to use each one's own sex-related vocabulary. For example, when a trainee is asked to name a particular body part, the answer is used in subsequent questions.
- (c) In keeping with a developmental theory of intellectual ability, an effort was made to grade test items in order of difficulty. Therefore, each section begins with concrete questions and proceeds to more abstract ones.

The first section of the S.D.I. is entitled Gender Identity. It contains ten videotaped segments of groups of people. Each segment lasts for approximately 30 seconds. Trainees are asked to identify the member of each group who is most like them, and to provide reasons for their choices. The section contains items such as a boy and a girl, a family group, three members of the same sex, and a nude male and female. Trainees score points for correct choices, pertinent reasons and answers which show a degree of abstraction.

Socio-Sexual Behaviours is the title of the second section. Here, trainees are asked to do some pretending, in relation to the vignettes. For example, they are asked to imagine they are married to the actor in one of the segments. Then a short scene is enacted, and each segment ends with the actor asking a question of the trainee. After this, the tester and the trainee discuss the reasons for the answer. Segments in this section cover the concepts of privacy, masturbation, contraception, pregnancy, venereal disease, coercion, and homosexuality. Trainees score points for correct answers, sensible reasons, and an understanding of the future consequences of present behaviours.

The final section focusses on Sexual Knowledge. In the first five segments, the trainees are asked to name body parts, and describe their functions. In segments six to eleven, they are asked to name various sexual activities, and to describe the next steps in the film sequences.

Given the sensitive nature of the subject matter, the administration of the S.D.I. requires two people. The first is the interviewer, who, in addition to asking the questions, is expected to be warm, supportive, and proficient in the traditional counselling skills. The second is an observer whose task is to score the trainees' responses. In this way, accurate records of the sessions are obtained while the interviewers are able to give complete attention to their interactions with the trainees.

A score of 550 is the highest possible on this assessment. However, when a group of 46 mildly retarded trainees were interviewed, they obtained a mean score of 291.49 ($s = 44.14$).

Preliminary work on establishing the reliability and validity of the S.D.I. has been encouraging. When used with mildly retarded adults, the attainment of a high value in a correlation of the split-halves, (Spearman-Brown Corrected $\rho = +.91$; $N = 46$; $p < .01$), suggests the test is reliable and internally consistent. Furthermore, on three occasions, different pairs of raters who viewed the 50-item assessment procedure demonstrated a high rate of inter-scorer consistency ($X\rho = +.93$; $p < .01$), thus indicating that objective measures of trainees' performances can be obtained. Finally, as a group of senior supervisory staff at the Vocational and Rehabilitation Research Institute (V.R.R.I.) in Calgary* assisted in the selection of videotaped segments, their agreement would seem to indicate that the S.D.I. has a degree of content validity.

Therefore, while the S.D.I. is in the early stages of development and much work remains, its reliability and validity have been established to an extent that gives it some relevance in the evaluation of sexuality training programmes. However, a major limitation is the unknown relationship between an S.D.I. score and the actual sexual knowledge, feelings and experiences of the trainee. In truth, we may never completely clarify this relationship, for, quite rightly, professional ethics and human rights prevent us from observing our trainees in many real-life situations. Consequently, findings from assessments of this kind should be evaluated with this limitation in mind.

Staff

Group leaders, test administrators, and interview raters were used in this study.

All 12 of the group leaders were experienced in the counselling of small groups. Six were employees of the V.R.R.I., four were graduate students completing practicum requirements, and two were from the Family Life Education Council of Calgary. They always worked in pairs, consisting of one male and one female.

In preparation for the project, all the group leaders took part in a short training course. This began with an evaluation of their attitudes towards sexuality and continued

*The author acknowledges the invaluable assistance of Dr. Roy Brown, the staff and trainees of the V.R.R.I.

with a series of remedial, de-sensitisation exercises which dealt with sexual slang and explicit visual aids. Then the actual programme was discussed and parts were rehearsed in order to illustrate important teaching points. This preparation period lasted from 4 to 6 hours, depending on the individual needs of the group leaders.

There were ten people who were administrators of the S.D.I. All of the four men were supervisory personnel at the V.R.R.I. Of the six women, four were also employees of the institute, while the other two were graduate students from the University of Calgary.

Before the study began, the test administrators received approximately four hours training. An initial attitude evaluation and de-sensitisation session was followed by the observation of an actual S.D.I. interview. Later, each interviewer performed a trial assessment on a trainee, while under supervision. In addition, decreasing amounts of supervision were provided over the next two or three assessment periods.

The S.D.I. interviews were scored by seven people, two men and five women. The men were both graduate students in educational psychology as were three of the women. The remaining two women were front-line workers at the V.R.R.I. The preparatory training of the raters consisted of the supervised scoring a number of assessment sessions. As they became more familiar with the score scales, and as their proficiency increased, the supervision was gradually withdrawn.

Table 1 — Demographic Data

Demographic Variable	Treatment Condition		
	Attention Only (n = 13)	Sex Education (n = 13)	Sexuality Counselling (n = 15)
Number of males	7	6	7
Number of females	6	7	8
PPVT I.Q. — mean	69.8	73.1	73.2
PPVT I.Q. — range	56-97	55-86	55-89
Chronological age — mean	21.9	23.9	23.8
Chronological age — range	17-30	18-33	18-34

PPVT = Peabody Picture Vocabulary Test.

Procedure

The subjects were divided by sex, and then randomly assigned to one of three treatment conditions. There were sufficient subjects for the formation of two small groups in each condition. Again, after controlling for the equal distribution of the sexes, subjects were randomly assigned to one of the small groups in their condition.

The first set of groups, a control condition, was named Attention Only. The subjects in these groups were able to form their own agenda, with the exception that discussions of sexuality were prohibited. Leaders encouraged subjects to discuss topics of common interest, and to plan short excursions to nearby coffee shops. The purpose of this condition was to control for the effects of subjects receiving attention from group leaders.

The second condition was Sex Education, with the subjects in these groups receiving a traditional, leader-directed programme. Lessons were given, films were shown, and questions were asked of the subjects. Group interactions and expressions of personal concerns were discouraged. The topics which were covered included anatomy, relationships, intercourse, contraception, reproduction, and venereal disease.

Table 2 — Sequential Outline of Experimental Procedure

Activity	Time Required
1. Selection of experimental population (Peabody I.Q. > 54; clear speech; normal hearing; physically mobile; C.A. < 35 yrs.) Total - 20 males and 21 females = 41 subjects.	
2. Groups balanced for sex, otherwise subjects randomly assigned to treatment conditions.	
3. Staff training	
Test administrators	3 to 5 hours
Test raters	3 to 4 hours
Group leaders	4 to 6 hours
4. Administration of pre-test	3 weeks
5. First set of training groups meet	4 weeks
Attention Only = 4 males and 3 females	
Sex Education = 4 males and 4 females	
Sexuality Counselling = 3 males and 4 females	
6. Post-test given, 2 weeks after completion of training	2 weeks
7. Second set of training groups meet	4 weeks
Attention Only = 3 males and 3 females	
Sex Education = 2 males and 3 females	
Sexuality Counselling = 4 males and 4 females	
8. Post-test given, 2 weeks after completion of training	2 weeks

The third condition was named Sexuality Counselling. Trainees in this course were encouraged to interact, to express their personal concern, and to participate in a number of rôle playing exercises which were modelled by the leaders. The curriculum contained six sections:

- (a) **Communication Skills.** Here, emphasis was placed upon the rôle-playing of introductions and general conversation, with particular attention being given to interpersonal space, eye contact, articulation, and identification of feelings.
- (b) **Dating.** In this section, the trainees rôle-played arranging a date in both face to-face and telephone situations. Both acceptance and rejection were rehearsed, while the underlying feelings and their appropriate expression were discussed.
- (c) **The "Where" and "When" of Socio-Sexual Behaviours:** This section was based upon the leaders' approval of sexual relationships between consenting adults in private places during leisure time. In addition to group discussions, the concepts of time and place were taught by means of rôle-playing in a variety of public and private locations.
- (d) **Sexual Vocabulary.** De-sensitisation and group learning were the focus here. Large, nude photographs of males and females were shown with the trainees being asked to repeat a number of slang and technical words for each of the sexual organs.

- (e) Developing a Sexual Relationship. This part began with an explicit film showing two people making love. Then the attitudes, experiences and feelings of the trainees were discussed, while the leaders stressed each individual's right to his or her own opinion. The consequences of sexual intercourse were emphasised and various kinds of contraceptives were handled, and their uses demonstrated. Finally, as an aid in teaching responsibility, the trainees participated in rôle-playing vignettes where, to a partner, they expressed concerns about contraception.
- (f) Countering Sexual Coercion. Essentially, this section consisted of assertiveness training in response to a variety of coercive sexual propositions. In addition, time was provided for trainees to work through previous negative experiences of this kind.

In this way, the Sexuality Counselling condition combined aspects of behavioural training with a small group dynamics methodology.

After being assigned to a group, all the subjects were given a pre-test, in the form of the S.D.I.

As mentioned above, due to the intimate nature of the materials, it is important that trainees have previously established a comfortable rapport with the test administrator. Consequently, the order of testing the subjects was dependent upon the availability of the administrators and the 4 or 5 subjects who were known to each one. The assessments were conducted in a testing room at the V.R.R.I., and the equipment included a 3/4-inch U-MATIC video cassette recorder/player (Japan Victor Corporation Model CR-6000U) and a video receiver monitor (Sony-Model 110U). An observation window and an audio system provided raters with the opportunity to score the interviews. Individual assessments lasted from 45 to 90 minutes, and all the subjects were tested during a three-week period. Brief summaries of the performances of individuals were made available to the group leaders.

Over the next four weeks, one group from each treatment condition met every weekday for one hour. During the following four weeks, the second group from each condition also met on a daily basis. Both sets of groups missed one meeting, due to the closure of the institute for holidays. Consequently, all groups received 19 hours of training.

During their last group meeting, all the subjects were informed that they would be asked to view the S.D.I. videotape again. These post-tests took place between two and four weeks after the completion of the group programmes. Again, order of testing was dependent upon the availability of the trainee and the interviewer, who was not informed as to the type of group attended by the subject.

Table 3 — Schedules of Group Leader Pairs A, B, C, & D

	Sex Education Group	Attention Only Group	Sexuality Counselling	Rest
Week 1	A	B	C	D
Week 2	D	A	B	C
Week 3	C	D	A	B
Week 4	B	C	D	A

It was difficult to find qualified leaders who had the time to work with more than one group per day. Consequently, in order to balance leadership skills across groups, four pairs of leaders were used with each of the two sets of three groups (see Table 3). This

meant that each pair spent one week of the month working with each kind of group, and also had a seven-day rest period. After each group meeting, a supervision period was made available to the leaders. Every Friday morning, a co-ordination meeting was held, wherein the leaders provided each other with information regarding the progress of the groups. In this way, the leaders were prepared for meeting with a new group each week.

Statistical Analysis

The effectiveness of the overall programme was evaluated by means of a single-factor multivariate analysis of covariance (Nie, Hull, Jenkins, Steinbrenner & Brent, 1975). The single factor included each treatment condition and, therefore, contained three levels, namely Attention Only, Sex Education, and Sexuality Counselling. Pre- and post-test S.D.I. scores were used in the analysis, with the former serving as the co-variate.

There were three dependent variables, each corresponding to a section of the S.D.I. These were Gender Identity, Socio-Sexual Behaviours and Sexual Knowledge. Univariate analyses of covariance were performed on each of the dependent variables, again with the pre-test scores serving as the co-variates. In addition, the differences between selected group means were explored using the conservative Scheffé's Test on the adjusted scores from the analysis of covariance.

RESULTS

The multivariate analysis of covariance indicated there was a significant difference between the groups of subjects, $F(9,105) = 24.31, p < .001$. On each of the dependent variables, the highest mean scores were obtained by the Sexuality Counselling group, with Sex Education next, and Attention Only achieving the lowest (see Table 4).

Table 4 – Sexuality Development Index

	Attention Only		Sex Education		Sexuality Counselling	
	X	s	X	s	X	s
Gender Identity						
Pre-test	74.69	(16.78)	72.85	(21.29)	71.67	(12.62)
Post-Test	74.62	(16.32)	78.46	(14.40)	86.33	(10.16)
Socio-Sexual Behaviours						
Pre-test	152.00	(27.02)	151.62	(27.67)	155.27	(17.41)
Post-Test	150.46	(20.39)	161.31	(21.80)	180.93	(22.20)
Sexual Knowledge						
Pre-test	59.92	(22.84)	67.31	(15.81)	69.13	(13.22)
Post-Test	56.77	(25.11)	82.62	(9.08)	91.40	(8.54)
Overall						
Pre-test	286.61	(54.01)	291.78	(50.62)	296.07	(27.80)
Post-Test	281.85	(50.17)	322.39	(38.87)	358.66	(30.55)

The corresponding univariate analyses of covariance on the 3 dependent variables also indicated that, in each case, there were significant differences between the groups:

- (a) Gender Identity, $F(3,35) = 66.45, p < .001$.
- (b) Socio-Sexual Behaviour, $F(3,35) = 40.99, p < .001$.
- (b) Sexual Knowledge, $F(3,35) = 26.43, p < .001$.

At this point, the dependent variables for Gender Identity and Socio-Sexual Behaviours were further explored, with regard to the location of the differences between the 3 groups. For the first variable, Scheffé's Test indicated there was a significant difference between the scores of the Sexuality Counselling and Sex Education groups, $F(1,38) = 16.76, p < .001$. In addition, a similar result was obtained for the Socio-Sexual Behaviours dependent variable, $F(1,38) = 28.72, p < .001$.

DISCUSSION

The test behaviours of the subjects suggest that intensive group sexuality programmes of this kind produce considerable overall changes in the S.D.I. scores of mentally retarded adults, and 19 hours of 60-minute, daily meetings are sufficient to demonstrate this effect. Furthermore, these changes seem to be greater than those achieved by traditional sex education programmes. As the main differences between the programmes lay in the areas of active participation, trainee-centred discussions, desensitisation, and rôle-playing, one is led to suggest that this combination of variables is an important component in producing positive changes.

Also, it appears that group sexuality counselling produces positive changes in the sexual self-images of this population. It is suggested that the discussion topics, the gender role models, and the acting out of assertive, adult behaviours helped the subjects to break down the common destructive cycle of passivity and poor self-image (Rosen, Clark & Kivitz, 1977). In other words, subjects who have been involved in the programme seem more likely to be comfortable in regarding themselves as adult sexual beings.

In addition, the work of Berger (1952) suggests that changes such as these are possibly accompanied by a general improvement in self-concept. Berger, who was working with paraplegic men found that a loss of sexual functioning was associated with a considerable deterioration in general self-image. Conversely, in the present case, one might speculate that a more positive self-concept would result from a clearer sense of gender identity.

With regard to socio-sexual behaviours, the experimental programme produced significant improvements in the S.D.I. scores of the subjects. As many of the items on this section of the assessment instrument focus on assertively predicting the consequences of certain behaviours, such as complying with coercive invitations and refraining from the use of contraceptives, it is believed that the programme might help to prevent sexual manipulation and abuse. Also, in contrast with those sex education courses which lack a substantial social component (AAHPER, 1971; Fischer & Krajicek, 1973; Kempton, 1975; Meyen & Carr, 1967), it is gratifying to note the apparently beneficial effects of the social aspects of the group counselling programme.

As stated above, the univariate analysis of co-variance on the Sexual Knowledge dependent variable yielded a significant between-groups main effect. This suggests that a significant difference exists in, at least, one of the possible combinations of the three groups. In addition, the subjects in the Sexuality Counselling group obtained a higher mean score than those in Sex Education, where information-giving was a major teaching technique, and the trainees in the Attention Only condition obtained the lowest average rating (See Table 2). Thus, wherever the between-groups significant difference lies, the subjects receiving group counselling must have shown a significant improvement

in Sexual Knowledge, and this increase was, at least, similar to that achieved by the people in the Sex Education condition.

Although the direct provision of information was not a major teaching strategy of the group sexuality counselling programme, the subjects in this condition still appeared to increase their sexual knowledge. This finding further illustrates a learning principle suggested by Brown and Dyer (1963). Working in the area of teaching mathematics to mentally sub-normal subjects, these authors contrasted academic and practical methods of teaching the subject matter. As with the present study, they found the practical approach also facilitated the learning of some underlying principles. As many front-line workers have previously suspected, it appears that some behaviourally-oriented programmes may have the additional bonus of aiding in the teaching of less-concrete, underlying concepts.

SUMMARY

The efficacy of two methods of sexuality training were examined. Mentally retarded adults (mean IQ = 72; mean CA = 23.2 years) received either Group Sexuality Counselling or traditional Sex Education course in 19 daily sessions, each lasting one hour. While subjects in both conditions demonstrated similar increases in Sexual Knowledge, those who received group counselling obtained significantly higher scores on measures of Gender Identity and Socio-Sexual Behaviours ($p < .001$). It is suggested that Group Sexuality Counselling is the more efficient method, for, beside producing a cognitive base for action, it also improves trainees' self-concepts and provides them with practical coping strategies.

References

- Abbott, J. M. & Ladd, G. M. 1970. "... any reason why this mentally retarded couple should not be joined together ... " *Mental Retardation*, 8(2), 45-48.
- American Association for Health, Physical Education & Recreation, & Sex Information & Education Council of the United States. 1971. *A resource guide in sex education for the mentally retarded*. Washington, D.C.: A.A.H.P.E.R.
- Berger, S. 1952. The role of sexual impotence in the concept of self in male paraplegics. *Dissertation Abstracts International*, 12, 533.
- Brown, R. I. & Dyer, L. 1963. Social arithmetic training for the mentally subnormal. *Journal of Mental Subnormality*, 9, 8-12.
- Carruth, D. G. 1973. Human sexuality in a halfway house. In F. F. de la Cruz and G. D. La Veck (Eds.), *Human sexuality and the mentally retarded*. New York: Brunner-Mazel.
- Fischer, H. L., Krajicek, M. J., & Borthick, W. A. 1973. *Sex education for the developmentally disabled: A guide for parents, teachers, and professionals*. Baltimore, Md.: University Park Press.
- Flavell, J. H. 1963. *The developmental psychology of Jean Piaget*. Princeton, N.J.: Von Nostrand.
- Gold, M. W. 1974. Research on the vocational habilitation of the retarded; the present, the future. In N. R. Ellis (Ed.), *International review of research in mental retardation (Vol. 6)*. New York: Academic Press.
- Gunzburg, H. C. 1969. *Progressive Assessment Charts (P-A-C) and manual*. London: National Society for Handicapped Children.
- Gunzburg, H. C. 1974. Psychotherapy. In A. M. Clarke & A. D. B. Clarke (Eds.), *Mental deficiency: The changing outlook, 3rd Edition*. New York: Free Press.
- Johnson, W. R. 1973. Sex education of the mentally retarded. In F. F. de la Cruz & G. La Veck (Eds.), *Human sexuality and the mentally retarded*. New York: Brunner-Mazel.
- Kempton, W. 1975. *Sex education for persons with disabilities that hinder learning: a teacher's guide*. North Scituate, Mass.: Duxbury Press.
- Marlett, N. J. 1971. *The adaptive functioning index*. Calgary, Alta.: The Vocational and Rehabilitation Research Institute.
- Marlett, N. J. & Hughson, E. A. 1979. *Rehabilitation programmes manual*. Calgary, Alta.: Vocational Rehabilitation and Research Institute.

- Meyen, E. L., & Carr, D. L. 1967. *A social attitude approach to sex education for the educably mentally retarded*. Iowa City, Iowa: University of Iowa.
- Nie, H. H., Hull, C., Jenkins, J., Steinbrenner, K. & Bent, D. 1975. *Statistical package for the social sciences*. New York: McGraw-Hill.
- Perry, M. A., & Cerrato, M. C. 1977. Structured learning training of social skills for the retarded. *Mental Retardation*, 15(6), 31-34.
- Rosen, M., Clarke, G. R., & Kivitz, M. S. 1977. *Habilitation of the handicapped. New dimensions in programmes for the developmentally disabled*. Baltimore, Md.: University Park Press.
- Rosen, M., Floor, L., & Zisfein, L. 1975. Investigating the phenomena of acquiescence in the mentally handicapped. Situational determinants. *British Journal of Mental Subnormality*, 21, 1-4.
- Thorne, G. D. 1957. Sex education of mentally retarded girls. *Am. J. of Mental Deficiency*, 62, 460-463.
- Wolfensberger, W. 1972. *The principle of normalisation in human services*. Toronto, Ontario: National Institute of Mental Retardation.
- Yalom, I. D. 1975. *The theory and practice of group psychotherapy*. New York: Basic Books.
- Zisfein, L., & Rosen, M. 1973. Personal adjustment training: a group counselling programme for institutionalised mentally retarded persons. *Mental Retardation*, 11, 16-20.
- Zisfein, L., & Rosen, M. 1974. Effects of a personal adjustment training group counselling programme. *Mental Retardation*, 12, 50-53.