

EMOTIONAL DISORDERS IN THE MENTALLY RETARDED

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Pursuant to the deinstitutional movement of retarded persons and re-entry into community placements, the nature of their emotional status in these new settings has been explored (AAMD, 1981; WING, 1981; Wing, 1981). As the primary psychiatric consultants to a local community-based system of services (Menolascino, 1977) which has focused on this challenge during the last twelve years, the authors have directly experienced the challenges and necessities of deinstitutionalization movement.

Herein, the types and frequency of emotional disorders in mentally retarded individuals served by a large community-based mental retardation system will be reviewed. The clinical problems most commonly associated with the different levels of retardation will be described. Professional challenges presented by the coexistence of these two major symptoms are discussed.

I. Types of emotional disorders in the mentally retarded

It has been reported that the mentally retarded display essentially the same types of emotional illness that befall people of normal intellectual abilities (Garfield, 1963). Recent professional literature repeats the theme that in the retarded the full range of psychoses, neuroses, personality disorders, behavior disorders, adjustment reactions, etc exist that are noted in the general population (Bernstein, 1970; Phillips & Williams, 1975). Other workers report a higher incidence and a different spectrum of psychiatric disorders among the retarded than in the general population (Donaldson & Menolascino, 1977; Chess, 1978; Menolascino, 1975). Some suggest that there are qualitative differences as well, so that some psychiatric conditions seen in the retarded may represent unique syndromes (Balthazar & Stevens, 1975; Collins, 1971).

Mentally retarded persons, even if emotionally well-adjusted, often experience some difficulty functioning independently in their community after extrinsic changes, (e.g. deinstitutionalization or leaving their primary family to enter a local group home). A need, therefore, exists for more information on the types of psychiatric disorders seen in community-based samples of the retarded, as a prelude to considering which treatment strategies are most effective.

The primary purpose of this study was to determine the types and prevalence of psychiatric disorders seen in a community-based population of mentally retarded citizens. It is significant that this study was in a community setting since the majority of previous studies on this topic have assessed retarded citizens in institutions where one may find both a high prevalence of psychiatric problems and more severe levels of retardation (Menolascino, 1972). Further, the current study assessed both retarded children and adults while previous studies in the community have often focused on only one chronological age segment of the retarded.

Clinical Sample

The setting for this study was a community-based system of services for the mentally retarded located in a five-county region of Nebraska which includes the city of Omaha (i.e. the Eastern Nebraska Community Offices of Retardation (ENCOR). To be eligible for the ENCOR system, an individual had to be functioning in the mentally retarded range as determined by an interdisciplinary team evaluation. The catchment area has a population base of 482,000 and is 80 percent urban. Since 1968, there has been a strong parent advocate and professional movement in Nebraska to decrease the number of retarded citizens in institutions; those who were discharged from an institu-

tion for the retarded to the catchment area automatically became patients in the program. The program is well known in the area and received referrals from local schools, social service agencies, health care agencies, private physicians, and directly from the families of retarded individuals. Accordingly, the resulting population of mentally retarded in the program was a representative cross section of all retarded citizens in the catchment area.

From January, 1977 to June, 1980, a total of 168 retarded individuals, or 21 percent of the total enrollment (i.e., 798) in the ENCOR system during this time span, were referred for psychiatric assessment. Each was individually evaluated. Of the initial 168 referrals, it was determined that 115 were both mentally ill and mentally retarded by the psychiatric consultant. These 115 individuals became the study group and represented 14.4 percent of the entire mentally retarded population in the ENCOR system.

Diagnostic Findings

The age range of the study group was from 6 years to 76 years. Those age 10 and under comprised 6 percent of the group. Teenagers, on the other hand, comprised 43 percent. Adults made up 51 percent of the study group with 20-year-olds accounting for 32 percent, 30-year-olds for 12 percent, 40-year-olds for 6 percent and those over 50 for 2 percent. The group was 66 percent male due to a disproportionately large number of boys between the ages of 6 and 15 years; there were 25 boys but only 11 girls in this age range in the study group. For all other age groups, males and females were found in approximately equal numbers.

It was not unusual to note *combined* diagnoses (in the same individual) such as chronic paranoid schizophrenia and moderate mental retardation, or an unsocialized aggressive reaction of adolescence and mild mental retardation. Certain diagnostic categories such as the neuroses were noted to be under-represented in this sample, while other categories were seen with relative frequency (e.g., schizophrenia and adjustment reactions). The diagnostic entities that were seen most frequently are listed in Table I, and are described in the next section.

As to formal psychiatric diagnosis, if the organic brain syndromes (O.B.S.) with behavioral or psychotic reactions are grouped together, they become the most frequent diagnostic group (27.8 percent), followed by adjustment reactions (21.7 percent) and schizophrenia (20.4 percent). The remaining 0.9 percent of the study group includes one patient with a psychoneurosis. It is of interest to observe that no affective disorders were seen in this group.

The diagnosis of an organic brain syndrome (O.B.S.) with a behavioral or psychotic disorder has been descriptively delineated in previous studies of psychotic disorders in the retarded (Menolascino, 1977). In the present study, criteria for this diagnosis was evidence of an organic brain syndrome by mental status, physical-neurological examinations, and/or personal-clinical history of etiologically significant factors. The diagnosis of *O.B.S. with behavioral reaction* was utilized for the sub-group who frequently displayed inappropriate acting out behaviors (e.g., emotional lability, impulsivity, sullen obstinancy alternating with aggressive outbursts, frequent tantrums, but no psychotic symptoms). The sub-group with evidence of *O.B.S. and psychotic disorder* present a different clinical picture than schizophrenia because: (1) the underlying organic brain syndrome signs and symptoms of the disorder were prominent; (2) their out-of-contact behaviours were not the type commonly seen in schizophrenia (e.g., no hallucinatory experiences), and (3) their personality structures did not show the progressive involvement of multiple segments of functioning which is characteristic of schizophrenia. Using these criteria, 21 percent of the study group was found to have O.B.S. with behavioral reaction, while 13 percent were diagnosed as O.B.S. with psychotic reaction.

TABLE I
Types of Psychiatric Disorders in Community-Based Sample of Retarded Persons

<i>Diagnosis</i>	<i>6-10</i>	<i>11-15</i>	<i>16-20</i>	<i>21-25</i>	<i>26-30</i>	<i>31-35</i>	<i>36-40</i>	<i>41-45</i>	<i>46-50</i>	<i>50+ Year</i>
<i>Schizophrenia:</i>										
Schizophrenia-Childhood		3								
Schizophrenia-Chronic Paranoid					2					1
Schizophrenia-Chronic-Undifferentiated			5	7	3		1	1		
Schizophrenia-Acute Undifferentiated				1						
<i>Personality Disorders:</i>										
Emotionally Unstable				2			2			1
Paranoid Personality							1			
Antisocial Personality				1	1					
Schizoid Personality		1		2		1				
Passive-Dependent		2		2	1			2		
Passive Aggressive			2	4	1	3		1	1	
Psychoneurotic Anxiety Reaction				1						
Adjustment Reactions	5	7	4	3	1	2	1	1		
<i>Organic Brain Syndrome:¹</i>										
With Transient Psychotic Reaction		4	5	1		2	1			
With Transient Behavioral Reaction	2	12	4	3						
TOTALS	7	29	20	27	9	8	6	5	1	2

N=115

¹ Although one could rightly argue that *all* mentally retarded citizens have an organic brain syndrome (especially the low-moderate and severely retarded), this O.B.S. designation is utilized herein in an effort to be consistent with the DSM,III nomenclature.

Personality disorders comprised 38 percent of this sample; those classified as passive-dependent comprised a sub-sample of 22 percent. Schizoid personality and emotionally unstable personality disorders comprised six percent, and the one patient with a paranoid personality disorder represented three percent of this category.

The 24 patients in the study group with schizophrenia included 17 with chronic undifferentiated schizophrenia (four of these had been diagnosed as childhood schizophrenia earlier in their lives), three patients displayed chronic paranoid schizophrenia.¹ One acute differentiated schizophrenia reaction was also noted. The patient diagnosed as having a neurosis was a 26 year old woman with a chronic anxiety reaction. Each of the major diagnostic categories will now be discussed as to their clinical dimensions.

Childhood Schizophrenia and Mental Retardation

Psychotic reactions of childhood have presented a major challenge to the clinician since their early recognition as distinct entities by DeSanctis in 1906. Delineation of types of etiologies has been delayed, in part, by the fact that the psychotic child

¹ It is to be noted that all of these patients had clearly documented clinical histories/examination findings of *both* mental retardation (primary disorder) and schizophrenia—thus representing instances of propf-schizophrenia (Lanzkron, 1957), rather than the symptom of mental retardation being a secondary sign of global personality regression (e.g., secondary to schizophrenia).

frequently functions at a mentally retarded level, and early observers believed that all psychotic children "deteriorated". In 1943, "early infantile autism" was described. Yet, to label a child "autistic" presents some formidable problems with regard to diagnostic and treatment considerations (Kanner & Eisenberg, 1955; Wing, 1981; Menolascino, 1982).

A number of follow-up studies (Menolascino & Eaton, 1967a; Rutter & Schopler, 1978) coupled with the literal rediscovery of the wide variety of primitive behavioral repertoires in the retarded, have tended to mute the earlier clinical enthusiasm concerning the functional psychoses and their inter-relationships to mental retardation.

In this study it was noted that three youngsters (ages 11, 14 and 15 years) displayed indices of both moderate mental retardation and childhood schizophrenia. The presence of bizarre behavior, persistent withdrawal, echolalic speech, and affective unavailability in early adolescents who had clearly experienced regressive symptomatology from an earlier higher level of functioning, was striking. These three early adolescents illustrated the superimposition of childhood schizophrenia (i.e., by past history the schizophrenic illness in all three had begun between ages 4 and 6 years) upon etiologically clear instances of mental retardation (e.g., one had Down's Syndrome, one was post-rubella, and the third had a major cranial malformation as the cause of his mental retardation).

Since treatment guidelines are markedly different for youngsters with "autistic" reactions to extremely bewildering extrinsic circumstances, and the combined mental retardation/childhood schizophrenia syndrome noted herein—this differential diagnosis is therapeutically significant beyond academic interests.

Adult Schizophrenia and Mental Retardation

Although some clinicians seriously question whether the markedly primitive behaviors noted at certain levels of mental retardation (e.g., severe level with associated poor language evolution) can be separated from schizophrenia, this was not our experience. Significantly, the instances of paranoid schizophrenia were noted in both verbal and non-verbal patients. Included in our sample of the latter, were three adults who drew out on paper their "attackers," replete with non-verbal gestures. One such young man would label his separate fingers as the "source" of his common delusions—which he would portray symbolically in crude drawing. Paranoid and catatonic features were the hallmarks of the acute-chronic undifferentiated schizophrenic groups. In the entire group of combined diagnoses of mental retardation and schizophrenia, it was noted that the altered affect responses, hallucinatory phenomena, bizarre rituals, and utilization of interpersonal distancing devices clearly marked the observed behaviors as being in the schizophrenic repertoire.

Personality Disorders

Personality disorders are characterized by chronically maladaptive patterns of behavior (e.g., antisocial personality, passive-aggressive personality, etc.), which are qualitatively different from psychotic or neurotic disorders (see DSM-III). Studies reported in the early history of retardation tended indiscriminately to view antisocial behavior as an expected behavioral accomplishment of mental retardation (Barr, 1904). The antisocial personality designation continues to receive much attention, and is frequently over-represented in mildly retarded individuals. It would appear that behavior problems of an antisocial nature are more frequently seen in this group for a variety of reasons (Menolascino & Strider, 1981). The same poverty of interpersonal relationships and developmental understimulation during childhood which can further aggravate instances of mild retardation can also lead to impaired object relations and poorly internalized controls. Likewise, it leads to reduced frequency of consistent parental/societal expectations and to a higher frequency of poor role models. The diminished coping skills of this group often necessitates their performing deviant acts

simply to exist, and reduced judgement makes the acts more ego syntonic. Finally, this group is most likely to be released from institutional settings in young adulthood and to illustrate graphically the effects of institutional detachment on personality structure.

It is interesting to note that although other personality disorders (e.g., schizoid personality) have been rarely reported in the retarded, we noted this disorder in five patients. The only other personality disorder in the retarded that has received much attention is the "inadequate personality," even though the application of exact diagnostic criteria would exclude this disorder as a primary diagnosis in mental retardation. In our experience the personality disorders occurred in mentally retarded individuals wherein the behavior was based primarily on extrinsic factors and had no distinct etiological relationship(s) to the symptom of mental retardation. The presence of personality disorders in 28 percent of our sample suggests that this group of disorders is not an infrequent accompanying psychiatric handicap for mentally retarded citizens.

Psychoneurotic Disorders

Early reviews (Beir, 1964) on this type of emotional disturbance in the retarded suggested that their frequency was quite low and the types of psychoneuroses reported were limited (e.g., anxiety reactions and depressive reactions). However, recent studies (Menolascino, 1967b; May & May, 1979) dispute the concept of incompatibility between neuroses and retardation, are quite explicit with respect to diagnostic criteria, and attribute the neurotic phenomena to factors associated with atypical developmental patterns in conjunction with disturbed family functioning. For example, psychoneurotic disorders in retarded children clearly link symptoms of anxiety (e.g., fear of failure and insecurity) to exogenous factors such as chronic frustration, unrealistic family expectations, and persistent interpersonal deprivations. Interestingly, these reports suggest that psychoneurotic disorders are more common in individuals in the high-moderate and mild levels of mental retardation, and have prompted speculation as to whether the relative complexity of psychoneurotic transactions is beyond the adaptive limits of the more severely retarded. These reported findings are not consistent with our experience of noting only one mentally retarded individual with psychoneurosis.

Adjustment Reactions (of Childhood, Adolescence, or Adults)

Although this category of psychiatric disorders is perhaps over-utilized in the assessment of the non-retarded, it is only infrequently employed during clinical assessment of emotional disturbances in the retarded population. In this study, the highest frequency of psychiatric disorders were noted to be Adjustment Reactions: 24 (or 29 percent) of the total sample. Mentally retarded individuals, by their frequency of organic predisposition towards over-reacting to stimuli and limited understanding of social-interpersonal expectations, are highly "at risk" for personality disorganization secondary to minimal interpersonal stress. In our experience, these Adjustment Reactions are most frequently caused by continuing inappropriate social-adaptive expectations, or unexpected and frequent changes in externally imposed life patterns. Clinically, they respond rapidly to environmental adjustment (when coupled with realignment of parental/residential/educational personnel's expectations or goals), brief utilization of psychopharmacological adjuncts, and supportive psychotherapy.

II. PROBLEMS ASSOCIATED WITH DIFFERENT LEVELS OF RETARDATION

The diagnoses of psychiatric disorders noted in this sample, and their incidence at differing levels of retardation are depicted in Table II.

TABLE II
Psychiatric Diagnoses and Level of Mental Retardation

<i>Psychiatric Diagnosis</i>	<i>Borderline¹</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
Schizophrenia	4	9	7	4
Personality Disorders	5	17	8	2
Psychoneurotic Anxiety Reaction	1			
Adjustment Reaction	2	7	14	1
O.B.S. with Transient:				
Behavioral Reaction	1	1	8	11
Psychotic Reaction		3	4	6
TOTALS	13	37	41	24

N=115

¹ *The designation of borderline intellectual level, though not utilized now (1982), was widely utilized at the time of this study. The levels of mental retardation, except for the noted borderline designation, are consistent with the DSM III nomenclature.*

The Severely Retarded

This group is characterized by gross central nervous system impairment, and a high frequency of multiple handicaps (in particular, special sensory impairments and seizure disorders). These problems directly hamper an individual's ability to assess and effectively participate in ongoing interpersonal-social transactions. Clinically, these patients manifested primitive behaviors and gross delays in their development. Primitive behaviors included rudimentary utilization of special sensory modalities, with particular reference to touch, position sense, oral explorative activity; and minimal externally directed verbalizations. In diagnostic interviews we noted much mouthing and licking of toys, excessive hand movements (frequently executed near the eyes), skin-picking, and body-rocking. From a diagnostic viewpoint, the very primitiveness of the severely retarded persons' overall behavior, in conjunction with much stereotyping and negativism, may be misleading (Wing *et al.*, 1977; Wing, 1981). For example, under minimal stress in an interpersonal setting, severely retarded children frequently exhibit negativism and out-of-contact behavior, and this behavioral response may initially suggest a psychotic disorder of childhood. However, with gentle prompting and minimal persistence on the part of the clinician, these children do make eye contact, and will interact with the examiner quite readily, despite their minimal behavior repertoires. Similarly, one might form the initial impression that both the level of observed primitive behavior and its persistence are secondary to extrinsic deprivation factors (i.e., a functional disorder); however, these children never seem to have possessed a functional ego at the appropriate chronological age, and there is an amorphic (or minimal) personality structure. The previously noted high risk status for psychiatric disorders in the severely retarded appears against the backdrop of this amorphic personality.

Recent studies on severely retarded children with rubella syndrome (Chess, Korn & Fernandez, 1971) clearly document the high vulnerability of these individuals to psychiatric disorders. It has been noted that without active and persistent interpersonal, special sensory, and educational stimulation (including active support of the

parents), these youngsters fail to develop any meaningful contact with reality (i.e., they display "organic autism").

We have been impressed by the extent of personality development the severely retarded can attain if early and energetic behavioral, educational and family counseling interventions are initiated and maintained. In adequately managed severely retarded children the paucity of language evolution, which is present typically, is a source of great vulnerability and blocks growth toward more complex personality development (Grunewald, 1972). Interestingly, these youngsters tend to be accepted by their parental support systems and peer groups (if adequate evaluations and anticipatory parent-patient counseling are accomplished), perhaps reflecting empathy for the obvious handicaps they display.

The Moderately Retarded

This level of retardation encompasses some of the same etiological dimensions noted above, accompanied by a wide variety and high frequency of associated handicaps. These individual's slow rate of development, their specific problems with language elaboration, and concrete approaches to problem-solving situations all present both unique and marked vulnerabilities for adequate personality development. In an outstanding study, Webster (1981) viewed these personality vulnerabilities as stemming from the characteristic interpersonal postures which moderately retarded children tend to use in their interpersonal transactions. These encompass benign autism (selective isolation), inflexibility and repetitiousness, passivity, and a simplicity of the emotional life—which reflects their relatively undifferentiated personality structure. These personality characteristics pose a clinical challenge in attempting to modulate their tendency toward direct expression of basic feelings and wants, as noted in their obstinacy, difficulties in parallel play situations, etc.

The limited repertoire of personality defenses, coupled with their concrete approaches tends to be fertile ground for over-reaction to minimal stresses in the external world.¹ Proneness to hyperactivity and impulsivity, rapid mood swings, and temporary regression to primitive self-stimulatory activities are characteristic of their fragile personality structures. Their previously noted limitations in language development further hamper their ability to communicate fully their inter- and intra-personal distress.

Unlike the severely retarded, this group of youngsters tends to be rejected by their parents and peers. Their significant attempts to approximate developmental expectations, coupled with the above noted behavioral traits, appear to alienate them from those very interpersonal contacts they so desperately need.

The Mildly Retarded

Recently, there has been perplexity over whether to view the mildly retarded as the statistical expression of the polygenic basis for the symptom of mental retardation, or as the untutored "have-nots" of our society. Emotional disturbances in the mildly retarded reflect the residuals of a person who is labeled deviant. The typical delay in establishing that these youngsters have a distinct learning disability (e.g., usually not confirmed until six to eight years of age), presents a mildly retarded individual with a constant source of anxiety in his or her inability to integrate the normal developmental sequences at the appropriate times in life. Usually, during the latent period of psychosexual personality integration, mildly retarded children have considerable difficulty in understanding the symbolic abstractions of school work and the allied complexities of

¹ Repeated observation of these particular personality features in the sample herein reported is a major reason the authors believe that the adjustment reactions are so commonly observed in psychiatrically complicated instances of mental retardation.

social-adaptive expectations from their family and peer groups. Although they often, at this stage in their lives, do gain some poignant insight (e.g., via adverse peer group transactions) into their "differentness".

The vulnerabilities of the mildly retarded often are not buffered or redirected by loved ones into new interpersonal coping styles to help correct earlier misconceptions about the self. Without some source of community support and direction, the mildly retarded are at high risk for failure in society—especially urban society. In the past, if they managed to avoid an institutional setting for the retarded, it was not unusual to find them, eventually, in other types of institutions such as correctional facilities or state mental hospitals.

In sum, it appears that this group is very likely not to be readily identified as handicapped to the extent of needing support. Rather, they are frequently seen as society's misfits who, if not simply ridiculed, are apt to be taken advantage of in far more serious ways, because of their relative lack of interpersonal coping skills. Herein the provision of professional guidance and family counseling can simultaneously serve both therapeutic and prevention goals.

III. CURRENT CHALLENGES

The work of Spitz (1945), Bowlby (1961), and other regarding the effects of early object loss and institutionalization has had a profound effect on all child-rearing practices. For orphaned children who are identified as emotionally or mentally handicapped, this work has virtually eliminated the large institutional orphanage in favor of foster care. These changes could have been justified for humanitarian reasons alone, but they have far greater implications for society in preventing the syndrome of the detached institutionalized adult who is too crippled to function in normal family relationships. In retarded individuals, the same principles apply. As recently as ten years ago, some of the most familiar sights in institutions for the retarded were the detached, mildly to moderately retarded individuals who tended to manifest basic expressions of the syndrome of detachment.

As the newer principles of care were applied, it has become increasingly apparent that much of the behavior thought to be typical of retarded persons is actually an expression of emotional detachment, and is therefore preventable through placing retarded children in small homelike settings wherein they will have a more limited and consistent group of caretakers.

In the past, one of the frequent reasons for recommending institutionalization of the retarded was the concern about the eventual appearance of "unmanageable" behaviors as they approach mid-adolescence or early adulthood. The tremendous improvements in medical and psychiatric treatment of these "unmanageable" behaviors during the last 20 to 30 years, has made possible revolutionary changes in the management of retarded individuals. Improved psychiatric treatment and management has permitted a dramatic decrease in the need for highly structured institutional methods of controlling problem behaviors. Isolation rooms, physical restraints, and excessive psychopharmacological regimes are increasingly the exception rather than the rule. Since these treatment challenges are now readily handled by psychiatrists in community-based settings, (GAP, 1979), the retarded individual and his family, physicians, and society as a whole have a greatly increased confidence that, for the great majority of the retarded, care can and should occur outside of the institutional setting.

With the advent of community-based programs for both the mentally ill and retarded, a series of mutually reinforcing events has unfolded. Many of the symptoms

of institutionalization have been prevented in the group of younger retarded persons, and the incidence of many types of psychiatric complications has been significantly reduced. The improved medical management of emotional and behavioral problems in the retarded has significantly increased the morale and confidence of persons who work with the retarded on a daily basis. The decreased need for staff control had made it possible to develop more comprehensive training programs for the retarded. All of these events have led to significantly increased opportunities for independent or semi-independent functioning for many retarded persons, and have made possible the rapid development of major locally-based systems of community services.

In addition to the advantages of avoiding the institutional syndrome of detachment, the community-based programs can provide a normalizing set of life experiences in the community with regard to school, recreation, work and home. They allow patients to be closer to families, to maintain close relationships with other caretakers, to live in an actual neighbourhood and homelike settings, and to be close to sources of sophisticated medical support.

SUMMARY

This study notes that retarded persons, because of their high incidence of central nervous system impairment and diminished overall inter-personal coping abilities, present a greater than average risk for developing associated psychiatric disorders. The types of psychiatric disorders noted and their incidence in a community-based sample of retarded citizens are described. Treatment challenges, including increased recognition of developmental issues and enhanced medical management, are reviewed. It is to be noted that all of these disorders were effectively treated within a generic community mental health facility (i.e. the Nebraska Psychiatric Institute in Omaha, Nebraska) which functions as the psychiatric back-up facility for a community-based system (ENCOR) for the mentally retarded. These observations, coupled with modern developments and achievements make it abundantly clear that the psychiatric handicaps of the mentally retarded are readily understood and amenable to contemporary psychiatric approaches. Accordingly, the findings of this study strongly support previous and ongoing trends toward decreased institutionalization and concurrent increased community living opportunities for all mentally retarded individuals—whether or not emotional handicaps hamper their life adjustments.

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