

SECTION D, SOCIAL SCIENCES

Psychotherapy With the Institutionalized Retarded¹

IRA GOLDBERG, Veterans Administration Hospital, Oklahoma City

The belief that psychotherapy may be of value with the mentally retarded is of fairly recent origin. One has only to peruse the literature of the last several decades to find much skepticism as regards its worth in the area of mental deficiency. To mention just a few, Hutt~~on~~ (1945), Healy and Bronner (1939), Morgan (1926), Paster (1944) and Rogers (1942) felt that retarded persons were unsuitable for psychotherapy. This long period of pessimism according to Sarason (1949) was based more on deductions from theoretical considerations than from empirical findings. This is in agreement with Burton (1954) who takes the position that criteria stemming from psychoanalysis has discouraged therapeutic attempts in this area.

Within recent years a more optimistic spirit has prevailed and the concept of psychotherapy with the retarded has gained general acceptance. The latter-day emphasis has been on making explicit the most suitable kinds of techniques. Both group and individual approaches have been used and within these approaches there are various disciplines which can be followed. Vail (1955) using group therapy, found the so-called non-directive method inappropriate. Ringelheim and Polatsek (1955) reported their group revealed "... no reflective insight and little capacity to offer solutions or interpretations of a meaningful nature. Verbal interplay was minimal and the therapist was constantly called upon to offer his solutions for the dilemmas presented" (1955: 159). Astrachan (1955) also reported that the retarded generally show a lack of interest in their own psychological processes and that when the therapist uses the standard of minimum interference, patients communicate very little. There is some agreement that the non-directive method of Rogers and the free-association technique of the psychoanalytic school are both unsuitable for a variety of reasons when applied to the mentally retarded. We cannot expect individuals limited in their capacity for self-examination, reflective-introspective thinking, conceptualization and verbal communication to make progress under the conditions imposed by each method. Yet we cannot conceive of the retarded individual as emotionally insensitive, unable to adapt to social values and with no aptitude for human relatedness. I believe we could accept as a fundamental principle of psychology the statement that "... man never gets beyond his experience and is therefore the product of all the experiences he has had up to and including the situation at the time of the observation" (Yepson, 1952: 206). Thus we might infer that the mentally retarded, while operating at a lower level of intelligence with its ramifications and consequences, are only quantitatively different from normals. Since they are limited in intelligence and the capacity to employ and use language concepts and abstract conceptualizations, the complexity of the personality or emotional disorders and the amount of insight needed are equally reduced. Consequently, psychotherapy with the retarded becomes as feasible as with the intellectually superior. However,

conventional techniques, concepts and goals must be altered in terms of both overall personal and social needs of the individual. This problem becomes even more significant when dealing with institutionalized defectives because of their special situation.

Most of us are aware of the fact that a diagnosis of mental deficiency really tells us very little about the individual. Specifically, the kind of people considered suitable for psychotherapy are those who fit into the group labeled as minimally educable, marginally dependent and perhaps trainable in terms of performing simple work functions. This will include many of the individuals psychometrically classified as morons and high-grade imbeciles but would exclude the severely retarded, many of whom lead a fairly vegetative existence. The latter group's extreme limitations would preclude the use of any existing psychotherapy involving verbal communication and a capacity to form meaningful relationships beyond the most infantile level.

A particularly appropriate definition of psychotherapy as applied to the institutionalized retarded is that it is a "... planned and intensive attempt by a professionally trained person to help another person learn to make a more socially acceptable and self-satisfying adjustment than heretofore was possible for him" (Sarason, 1952: 803). Thus our most important objective is to help the institutionalized defective reach a point of greater stability in a context of increased self-satisfaction whereby he is able to adjust to the artificial yet altogether real environment in which he is required to live. As regards this environment, one of the most pressing reality factors confronting the institutionalized defective is the relative rigidity and inflexibility of his world which can be modified only according to the wishes of the administrative, professional and attendant personnel. This kind of environment frequently provides a sense of security for many individuals who then are not required to make the kinds of everyday conflict-choices which most of us are forced to make. However, two extreme kinds of reactions can result from being forced to live in a chronically unsatisfying and frustrating environment where one lacks motility and is powerless either to cope with the environment, to change it or to move out of it. The individual may psychologically leave the field in terms of withdrawing into a psychosis or develop a chronic and chaotic type of asocial and rebellious behavior.

In general, the non-conforming individual, like the irresistible force meeting the immovable object (in this case the institution with its hierarchy, rules, philosophy, traditions and limitations on personal freedom) comes out of the scrape 'bloody and broken', so to speak, unless he manages to alter his behavior so as to be more acceptable to those around him. These are often the very individuals who eventually become the most compliant and what has been termed "well-institutionalized." This resultant does not fit in with our goals of psychotherapy since more socially acceptable and self-satisfying adjustment does not imply the creation of institutional automatons.

One of the most striking characteristics of mental defectives is that far from being autistic, they tend to be externally bound and hypersensitive to reality. They are over-dependent on the environment for satisfaction and continually seek approval, praise, affection and recognition or at least some kind of response from others. From this frame of reference it appears that the rebellious defective is doing more than expressing aggression simply because he lacks constructive inner controls by which he can more adequately handle his feelings and impulses. It appears that this kind of behavior frequently occurs because the individual is seeking some kind of response from his environment which would be compatible with his self-concept. That is, he is attempting to fulfill his self-perceived

role which frequently developed as a consequence of having suffered the most extreme kind of rejection and humiliation in the past. Thus he continues to fight against something or someone who is perceived to be over-critical, disrespectful and rejecting while at the same time he continually tests the environment in an attempt to solidify his own role as unworthy as he may perceive it to be. He challenges authority and seeks punishment and deprivation while outwardly denying his need for love and acceptance. He feels as a result of bitter experience that these needs can never be met and in addition he could never accept these things from others because they would be inconsistent with his feelings of unworthiness. Continued expression of aggression leads to an increase in realistic rejection. This serves to reinforce his unacceptable behavior which can then be justified by him on a reality basis. Thus the environment becomes increasingly well structured and further aids him in his attempts to gain clarity in fulfilling his role in life.

It appears to me that the most appropriate therapeutic approach has to take into account both the patient's internal world and the very real institutional world in which he is required to live. Within the therapeutic context a fairly directive approach in which the therapist plays a more active role seems to be important. However, while experiencing feelings, ventilating emotions and developing insight are important, they are not in themselves enough to create the kinds of changes required. In the absence of comfortable inner controls, methods of resisting frustration and achieving emotional control must be explored with the patient in a fairly direct and open manner. An attempt is made to break the vicious cycle of hostility, leading to counter hostility, rejection and then reinforcement of unacceptable behavior. This is partially done by means of exploration of feelings and motives but there is also a concrete outlining of probable consequences of unacceptable as well as acceptable behavior. This is really a pointing out of reality to the patient in a very concrete way. It is at this point that cooperation among all levels of staff becomes crucial since the therapist should be in a position whereby he is able to predict some of the important consequences of his patient's actions, acceptable or not. This is really a situational or environmental therapy because there is a consistency of program which includes the use and control of persons, things and activities the individual lives with in order to help him overcome his emotional difficulties.

What I am saying is that the total environment, including staff at all levels, must be considered in this context an integral part of the therapeutic armamentarium. This means that the therapist, having a dual responsibility both to the administration and his patients, will have to come to terms with his own professional role and responsibilities. He is also required to maintain good working relations with other staff personnel, so that if specific changes in the patient's everyday routine are going to facilitate positive internal changes, there will be cooperation among the powers that be. It may be important for him to prepare significant personnel for subtle changes in the attitude or behavior of his patient so that their handling of the situation will be appropriately therapeutic. Without revealing confidences, it is important that the staff understand what he is doing so as to give them an opportunity to share the experience of his therapeutic efforts. This will help to minimize the amount of displaced hostility thrust upon his patient by employees of lesser status, who, in addition to having feelings of guilt, may resent the patient being singled out for individual attention.

One can never expect the total behavioral pattern to change all at once. However, it is hoped that the individual gradually gains a new perspective of himself and the world whereby his psychological set, in terms of anticipating rejection, is altered. It is further hoped that he will reach

a point when felt and experienced rewards from acceptable behavior will outweigh the feelings of satisfaction gained from expressing aggressive or unacceptable behavior. This has an ongoing, reenforcing effect on the new and more positive aspects of ego or self which are emerging as a result of affective experiencing and insight. He now makes attempts to establish and solidify his new role in life and seeks more positive and productive experiences to enhance his increasingly more positive self-concept.

Although not touched upon until now, the transference relationship seems to be initially the chief therapeutic agent in helping to create change and facilitating a relearning of the social rule. Without wishing to argue the point as to whether the therapist's values should influence his patients, suffice it to say that with mental defectives the therapist is in the unique position of influencing behavior in terms of leading the patient to inhibit certain responses while increasing the frequency of others. It is realistic to expect that the values of the institution, as represented by the presence of the therapist, will be imparted to the patient who may eventually incorporate them as they become more compatible with his own values. As he comes to perceive the therapist in a more positive way, so will he eventually perceive his world, and significant people in it, more positively.

Good adjustment to an institutional setting, to repeat, does not imply the creation of institutional robots. However, it does suggest for these individuals increased ego-development and maturity, a more positive notion of self with increased feelings of worthiness and an increased capacity for controlling impulses and behavior in a context of more satisfying interpersonal relationships.

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