

# OVERCOMING OBSTACLES TO COUNSELLING WITH THE MENTALLY RETARDED

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Mental retardation is a widespread condition. Twice as many Americans are retarded as suffer from poliomyelitis, cerebral palsy, blindness and rheumatic heart disease combined. Only mental illness, cardiac disease, arthritis and cancer are more prevalent. An estimated three percent of the U.S. population, about seven million people, are affected. Some 126,000 new cases are diagnosed each year (Mandelbaum, 1977).

## I. Social Aspects of Mental Retardation

While mental retardation has many causes, among which are a variety of physical and genetic factors, the influence of socio-economic factors in its etiology should not be overlooked. This has important implications: **Much mental retardation is preventable.** Epidemiological studies indicate that brain damaged individuals are found in all social classes in a random distribution. However, those retardates without organic impairment come in disproportionate numbers from the ranks of the poor. For example, among the mildly retarded less than one percent come from high income, well educated families, while about fifteen percent are found in families living in urban slums or impoverished rural areas. (Ibid.) Thus the overwhelming majority of the mentally retarded come from the lowest socio-economic group.

Arthur Mandelbaum, reflecting upon the impact of early environment on later intellectual capacity, indicts "illiteracy, extreme poverty, poor diet, substandard housing, crowding, poor hygiene, and illegitimacy" as factors contributing to low infant birth weight and retardation. (Ibid.) He adds:

Epidemiological findings from a host of studies show astonishing correlation between the incidence of mental retardation, particularly in its milder forms, and the adverse socioeconomic and cultural status of families and population groups.

Although it is necessary to caution that neither the mentally retarded nor the poor can be viewed as a homogeneous group, lack of parental care, prematurity, dietary deficiencies, malnutrition, and undetected diabetes (which are more likely to occur among the poor), raise the risk of brain damage and mental retardation. In addition, poor and inconsistent infant care and lack of pediatric attention raise the risk of susceptibility to infection. (Ibid)

Another scholar asserts, "Chronic early-life malnutrition (during the first year) . . . is a probable cause of cognitive deficiencies." (Shneor, 1976)

The linkage between mental retardation and life conditions finds unequivocal endorsement in an article by Benjamin Pasaminick in the American Journal of Mental Deficiency. He says:

It is now possible to entertain a new *tabula rasa* theory hypothesizing that at conception individuals are quite alike in intellectual endowment except for those quite rare hereditary neurological defects. It appears to us that it is life experience and the socio-cultural milieu influencing biological and psychological function, which in the absence of organic brain damage, makes human beings significantly different from each other. (Pasaminick, 1959)

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There exists yet another dimension to the social aspect of mental retardation. Behaviour is more than a function of intelligence. A number of variables affect the individual's social performance and when we speak of mental retardation we really are talking about an impairment of adaptive behaviour, not merely a deficiency in I.Q. score.

Moreover, many of the retarded are victimized by prevailing stereotypes which become self-fulfilling prophecies. Labelled "stupid," "retarded," "unable to learn," segregated into special classes in school and isolated from peer friendships by the fears of parents of "normal" children, the retarded lead stigmatized, needlessly constricted and underproductive lives.

The retarded, with few exceptions, are painfully aware of what others think of them, and are aware of their second-class treatment. In reality, the great majority of the retarded are physically indistinguishable from others, and intellectual differences are of degree, not kind. The essential difference is a slower rate of learning. Because of this difference a series of ultimately significant social distinctions are generated which separate and stigmatize the retarded.

Another pitfall lies in cultural differences. Black and brown children do not score well on conventional intelligence tests and risk being misdiagnosed as retarded.

We now consider some aspects of direct service to this client group.

## II. Some Elements of Effective Helping

There exists a persuasive body of evidence that effective counselling, helping people to help themselves, through whatever name or discipline — psychotherapy, casework, vocational counselling — and in whatever field, including mental retardation — requires a cluster of attributes which have been identified and can be taught. This is not to deny the importance of personal qualities. Indeed, the necessary skills and the personal characteristics are closely related.

An extensive body of research indicates that counselling **does** affect people. They are influenced by the interventive process, either for better or for worse (Carkhuff and Berenson, 1967). Effective helpers were found to possess certain characteristics, the presence of which influenced improvement, the lack of which influenced client deterioration. These traits affected performance in every helping discipline — *social work, psychiatry, psychology, nursing, law, medicine, teaching, vocational counselling, etc.* These traits were also more important than the person's theoretical orientation — Freudian, Rogerian, Existentialist, etc. Moreover, it did not matter whether the client group comprised alcoholics, schizophrenics, delinquents, or any other definable group.

The first of these crucial traits is **empathy** — the ability to identify another person's feelings accurately and to convey this awareness to the person.

**Respect** is another — appreciating the dignity and worth of the other and the latter's right to make his own decisions; it involves a belief in the other's capacity to make something of his life.

A third is **genuineness**. This is the ability to be yourself, non-phony, non-defensive, not playing a role or hiding behind a facade. "What the client sees is what he/she gets."

A fourth is **warmth**. This is the ability to express caring and concern, both verbally and behaviourally, rather than being detached and aloof.

A fifth is the ability to engage in **confrontation**, compelling a client to deal with his discrepant behaviours, for example the contradiction between what he is saying and what he is subjectively experiencing, or what he is saying and what he is currently doing. Of course timing is important and when confrontation occurs the counsellor must be prepared for the client's anger.

Other such significant traits have been identified elsewhere (Wolf, 1974-75).

A necessary complement to the helping process involves the client's readiness for change. Several points are noteworthy.

1. **Change** is a form of learning. It is not necessary to think of personality reorganization or "insight." People may change even without inner transformation.

2. Change tends to be initiated when some tension or imbalance or dissatisfaction exists, i.e., when the person is experiencing **discomfort**.

3. At the same time there must exist in the person's mind some goal which, if achieved, will reduce or eliminate the discomfort. The goal must also be perceived as attainable.

These two conditions have been referred to as "The push of discomfort and the pull of hope." (Towle, attributed).

4. Change tasks must be geared to the client's capacities. Too much too soon puts the person under excessive pressure and in self-defence he/she may pull back. People may protect themselves by disengaging from overpowering relationships.

Motivation for change should be assumed. Most people wish to achieve in order to cope with life as effectively as possible. This is true in all of nature, i.e., the impulse toward growth and self-reliance always manifests itself. Thus the client is our ally.

However, though change is desired and satisfying, the required process of change may also be painful. People may fear to risk failure, or to expose their vulnerability or perceived inadequacies.

5. Change is meaningful and lasting only when the client actively participates in achieving it. This is because change takes place within the client. Change depends not on what the counsellor does, but on what the client does.

6. Finally, any new learning must be applied. "Actions speak louder than words." Trying out the change is essential if it is to "stick".

To support the client's desire for the greatest autonomy of which he is capable we offer the helping relationship, employing the positive counsellor traits identified earlier and the counselling skills developed by our own discipline. In addition, we have the agency's and community's resources.

We turn now to a consideration of what I have referred to elsewhere (Berliner, 1979) as the:

### III. Four "Deadly Sins" in Working with Clients

The first is **Stereotyping**. This involves acting as though all mentally retarded are alike. However, the mental retardate is an **individual**, an idea to which everyone readily gives lip service, but which is abandoned when we become too mentally lazy to individualize our clients. The fact that any group possesses some identifiable trait in common — race, religion, ethnicity, income, mental subnormality — may lead to the all-too-common habit of treating members of this group as though they possessed all other characteristics in common. It is ridiculous to talk about "them" — Blacks, Catholics, Schizophrenics, millionaires, retardates, college professors, Jews, engineers, cab drivers. The "them" implies that you can fit each diverse human being into a group with which he may actually share only one, or a few characteristics — his skin colour, or income, or religion, or political affiliation. We rightly object when we are stereotyped by clients. It is just as erroneous, and it will retard understanding of the unique individual who is our client, to put him/her into a category which makes him indistinguishable from millions of others. Science seeks to further our understanding by making generalizations but it is a misuse of the scientific method to generalize away the uniqueness of each client. We cannot convey respect to our client if we stereotype him as part of a class of beings with whom he may have very little in common except a symptom.

2. A second deadly sin is that of **overemphasizing symptoms**. We may become so preoccupied with the diagnosis, with what is "wrong," that we fail to recognize and respect the person's successes in living, what he/she is managing to accomplish in spite of handicaps. After all, it is the person's assets that we must build upon, not his liabilities, and if we tend to focus on the latter we are likely to develop a pessimistic view of his prospects for change. This will adversely affect our own performance.

3. A third deadly sin is that of **ambition**. If we need to live off client successes, i.e., satisfy our personal needs for achievement through client achievements, we place an inordinate and unfair burden upon these clients. The client's success (or failure) is his or hers. If, however, our professional esteem requires that the client succeed, then we end up exploiting the client for our own ends. We may fail to set reasonable goals and expectations and thus make it more difficult for the client to achieve the more realistic and limited achievements of which he is capable. The sin of ambition may also induce us to try to do it all ourselves, thus ignoring the potential help available from other resources which the client may need and could use.

4. The fourth (but by no means least) deadly sin is playing the "rescue merchant" game. This is the opposite of being too ambitious. In this case we encourage the client's dependency and helplessness. Clients sometimes assume such a posture in an effort to get us to do more for them than is really necessary. It may be difficult sometimes to resist this seductive appeal to our power and beneficence. After all, are we not in the picture in order to be helpful? But in taking over we ignore a crucial requirement of effective helping. We do **for** instead of **with** the client. We take over in lieu of engaging the person himself. We need constantly to ask ourselves whose needs are being met, whose plans and decisions are being carried out. Moreover, the more thoroughly engaged the client is in developing his own plans the more likely the client will stick with his decisions and carry them out.

We now turn to the "significant others" in our clients' lives.

#### IV. Working with Families

Friends, employers, fellow workers and, in most instances, family members, play significant roles in shaping our thoughts, feelings, and actions. While this seems an obvious truth, we do not always act as though we are mindful of it. Too often we fail to connect a client's behaviour with what may be going on in his relationships with others, or we may regard the client's family as a nuisance which interferes with our efforts; alternatively we may scapegoat family members, considering them responsible for the client's plight. These attitudes make it more difficult for the client and they undermine our helpful intent.

The perspective here advocated recognizes that "each person is embedded in a network of social statuses and social roles, the effective performance of which requires the reciprocal performance of others" (Berliner, 1977). To be labelled a retardate requires some degree of societal consensus. Others must treat the person as retarded and, in consequence, the person tends to accept this definition and perform the role as he understands it. This follows from the fact that societies prescribe rules for establishing an identity and rules for behaving in conformity with that identity.

Mental retardation is an identity, a status and a role, and there are certain more or less typical reactions individuals experience when confronted with it in another. This brings us to families, the "significant others" in the lives of mentally retarded persons.

The reactions of parents learning their child is retarded, may follow a sequence. First there is likely to come denial — "This can't be true," followed by grief — guilt — and anger. The grief is a form of mourning for lost hopes and for the death of fond expectations for a perfect child. The anger has to do with "Why us?", the resentment over this unfair blow of fate. The anger may even be directed against the child. The guilt signifies feelings of self-blame — that, somehow, it is the parents' fault they have produced an "imperfect" child. Over time these reactions may dissipate. Not infrequently, however, these feelings, while attenuated, persist below the surface and make it more difficult for the parents to cope with problems and to participate in cooperative planning with the helping person.

Experience indicates family reactions run the gamut: difficulties may be understated in order to minimize knowledge by "outsiders" of the family's "dirty linen"; on the other hand, families may exaggerate the client's problems to gain sympathy and support or to appease the guilt they feel for putting their relative into other people's care. The client may be exploited by his/her family as a scapegoat, the convenient "cause" of difficulties and tensions which may be disrupting family equilibrium.

Parental reactions are influenced by the child's degree of impairment, and our cultural norms and values (e.g., that children should develop independence and self-control). Reactions tend to occur in a sequence beginning with subliminal awareness, followed by overt awareness, recognition of the problem, seeking a cause, seeking a solution and, finally, realistic acceptance of the situation. Each reaction is accompanied by certain typical responses, e.g., denial, or anger toward the child, etc.

The parental reactions are normal. They become problems only if parents become trapped in these stages. It should also be kept in mind that the sequence of reactions presented represents a theoretical model and that in real life there will be modifications as well as a "back and forth" movement among the stages until resolution (acceptance of the situation) is achieved. Parental guilt may be intensified by therapist reactions of anxiety regarding handicaps, blaming the parent, or stereotyping the parent, i.e., seeing all parents of handicapped children as the same.

For better or worse, most mentally retarded either remain in, or will return to family life. Therefore we would be well advised to pay attention to the client's close relatives. Obviously they are both a source of information about the client and a potential resource in his life. Beyond this, their attitudes toward the client and his treatment, as has been suggested, will have a great deal to do with success or failure of rehabilitation efforts.

The basis for this may be the recognition that every social group tries to maintain equilibrium. It develops rules, standards, traditions, etc., which make life easier and more predictable for group members. The family is the most basic and important such social group. Family equilibrium is challenged or disrupted when major changes occur for any of its members. Given that, within the family group a "strain toward equilibrium" exists, the disruption threatened by a member's chronic disability requires some family response which will restore equilibrium. There are many possible responses, including some which bode ill for the client's well being.

The family might 'dump' the retardate into an institution, then close ranks to exclude the absent member, thereby gaining a new equilibrium without the client.

The family might deny the reality of the member's retardation, thereby wishing away the problem. Supposedly there really is no problem, hence no disruption of equilibrium need occur. Unfortunately, the retardate's needs for special help are thus denied. In such instances, too, the agency worker becomes a perceived threat to the family because he is the messenger bringing the bad news.

Helping families to face and deal with the multiplicity of problems generated by mental retardation is one of the most important tasks usually connected with the social worker's role. It is important to facilitate family engagement by providing client care at or in a facility in the person's own community. Far from regarding families as nuisances, staff time should be budgeted for family interviewing. If the client is institutionalized, flexible visiting hours should be established so that interaction between staff and relatives of the clients are a structured expectation, not a catch-as-catch-can occurrence. Finally, family members are more likely to be amenable to our intervention into their lives if they perceive in us:

1. An attitude of "therapeutic optimism"; almost always something constructive can be accomplished, some improvement can be achieved.
2. An attitude of support which recognizes relatives' burdens of grief, uncertainty and concern rather than imputing blame which too frequently they sense from others and may feel in themselves.

## Final Comments

In closing three important points are reiterated:

1. Research and clinical experience in a variety of settings (Ackerman, 1970; Jackson, 1960; Reiner and Kaufman, 1961) underscore the importance of seeing the client in a larger perspective, typically that of his family. This needs to be the "unit of treatment."

Since in most cases the (client) will, or should return to his family it is the better part of wisdom to regard him as a temporarily absent member and it is family reintegration on a more mutually satisfying and productive level that must be sought.

If the (client's) return to his family is a generalized goal then to protect the integrity of the plan the (counsellor) must secure active engagement of the family members in ongoing planning. This forestalls family members prematurely closing ranks, sans (client), in an understandable effort to reestablish the family system equilibrium which had been disrupted by the (client's) departure (Berliner, 1979).

2. People learn best and retain what they do. It may be easier on us to do things or make decisions for people, but if the goal is independence or maximum functioning of the other person it is more productive to support maximum client autonomy. The principle to follow is: Never do for a person what he can do for himself. When dealing with the retarded the worker may need to exercise all the imagination and determination of which he/she is capable in order to implement this principle of client self-determination.

3. Change tends to be incremental, not exponential. We must be satisfied with small gains achieved over substantial periods of time. But we must persist. We owe this to our clients and to our own professional commitment to service.

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