Psychotherapy for Special-Needs Adults and Their Families

Part Two: Clinical Issues for Clients, Families and Therapists

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This article is the second part of a two-part series about psychodynamic psychotherapy for special-needs adults, including those who are intellectually challenged or have autism, Asperger syndrome, or Down’s syndrome. It describes issues particular to families that include special-needs members, and for the therapists providing their treatment. Part one appeared in the June issue of this newsletter, that can be found archived online at www.clinicalsocialworksociety.org.

SPECIAL ISSUES FOR FAMILIES

Clients and their families must come to accept that these disorders are partially remediable, not curable. The chronic nature of the difficulties with special-needs offspring causes suffering in every parent of children with developmental disabilities. Even with a great deal of help, most parents experience periods of despair over the taxing nature of this responsibility. While many families are able to provide appropriate support (especially if they have other areas of gratifications in their lives), some become so enmeshed with their special-needs children that they achieve gratification by always being needed, resulting in less differentiated relationships.

Mourning: One of the most challenging tasks for families with a special-needs member is mourning. With a son or daughter who has a serious cognitive impairment one must mourn what will never be a “normal life” with a predictable future, independence, marriage and children, and caring for parents in the future. Very few, anticipating the joys of parenthood, can be happy to discover that they have a child who will be a lifelong responsibility, who will always require special care, and who will not be able to care for their parents as they age.

Therapists can help families with the necessary part of the mourning process that involves setting realistic goals based on ability levels of their sons or daughters. The special-needs adult will need similar help. Carl sought treatment after years of sadness about not being able to realize his dream of becoming a doctor. Carl has Asperger syndrome and mild retardation, making his hopes unobtainable. In treatment, he was helped to adjust to a career of repairing computers, an occupation more suited to his talents and abilities that did not have the upsetting distraction of the complex social relationships inherent in the medical field. We reframed his difficulties with Asperger syndrome as positive in this work, which required his excellent capacity to focus and to work diligently.

It is a mistake to assume that special-needs people are unaware of differences between themselves and others. They are very aware of what they may not have in life, and therapy can help them deal with these issues. One client’s acting-out
behaviors were the result of unrecognized and untreated grief. He wanted to be like his sisters—to be married and have children. Until he was able to talk and write about his unrequited love, and to be understood for his anger and his sadness, his perseveration overwhelmed him and his family.

Confidentiality: Others need to know about the nature of the person’s ability and needs of the family in order to offer necessary support or services. In addition, unusual physical characteristics make many people with developmental disabilities easily recognizable as different. In light of the public nature of the disability, making psychotherapy a sacred space is especially complicated, but vital.

Pride and Visibility: A common clinical issue is helping special-needs people maintain pride in themselves, while accepting the level of help they may need in order to maintain adequate functioning. Dual treatment tasks, are to allow them opportunities to express any discomfort, shame, or anger about their disabilities while gaining pride in their accomplishments. One client is proud of working and of taking the bus, another has pride in her volunteer activities and horseback riding achievements. Although both women are vastly different from those of their high achieving professional families, each recognizes that not everyone has their unique capabilities and strengths.

People with Down syndrome are particularly likely to know that those around them see them as different, often as unacceptable, and are apt to feel undesirable and unlovable. Some may try to be accepted and liked by being compliant and smiling. Sinason (1992) suggests that since many of these people are ridiculed because of their unusual appearance, one could even call their environment traumatogenic. Therapy can help them cope with ridicule, avoid physical and sexual abuse, or heal from these experiences if they have already occurred.

Dependency Issues: Parents’ reluctance to allow their adult special-needs children increasing independence is complicated by the fact that doing so exposes their offspring to societal risks. Physical, psychological, and sexual abuse occur with great frequency within this population. This happens for several reasons, among them their wish to please and their naïveté about protecting themselves. Many families need help allowing their disabled member to manage as much independence as they are able to handle, appropriately teaching them to be as safe as possible, providing a safety net as needed.

Life-long Responsibilities: Families of special-needs children will continue to face ongoing financial as well as emotional demands in raising and then supervising or assisting their adult children. In addition, sibling resentment can ensue, because of the disproportionate attention to the special-needs child and because of the stigma about having a sibling who in the eyes of the world is not normal. Tony’s parents were distressed that he never brought friends over to play or spend the night. Family therapy revealed his shame and embarrassment about having his friends see his compromised older sister. Treatment can help family members in this daunting task, providing a safe environment in which to explore their feelings and find new solutions.
Planning for the future: Concerns about the future plague most parents of special-needs children, especially as they and the special-needs member age. What will happen to their offspring? Who will care for their needs? Some parents use denial to cope, leaving others to face this problem after their demise; others make plans to the best of their ability, establishing special trusts, conservatorships, and residential care plans. At the same time, people with special needs are also terrified about what will happen to them as parents age or get sick and die. Having plans in place for such eventualities can help both parent and child face the future with less fear.

SPECIAL ISSUES FOR THERAPISTS

As stated earlier, working with this population requires an unusual amount of patience and willingness to be flexible in order to work not only with the individual but also with parents and with social agencies. Progress may be extremely slow and arduous. The role of the therapist in assisting these families is pivotal and challenging.

Transference and Countertransference: The therapist’s ability to deal with both transference and countertransference is integral to success. This means that the therapist must be willing to be emotionally immersed in the material, not be overwhelmed by its intensity and poignancy, and respond according to the needs of the client. Clinicians need to be able to recognize and understand their own feelings and reactions and use these to understand the client. Those who do not have this ability become defensive, finding ways of stopping the clients from being expressive. They mask their discomfort by being directive with their clients, making ill-timed interpretations, giving unnecessary information or instructions, or prematurely terminating treatment.

Typical reactions by therapists treating special-needs clients include fantasies of healing or rescuing them, or experiencing anger at parents who seem unreasonable, infantilizing, or abusive. Understanding the source of these feelings can help the therapist to not act on them by becoming inappropriately involved or taking sides against parents. Of course, outright abuse must be reported. Arlene, a forty-year-old woman with Down’s syndrome, had been in weekly therapy sessions for many months. She was excellent at being compliant, and she was generally well liked and accepted. Having gained comfort within the therapeutic relationship, one day she bravely proclaimed, “I hate to look into the mirror!” “Why?” the therapist inquired. “Because I hate to see that face in the mirror and know it is mine,” Arlene answered. Stunned for a moment, the therapist resumed her mode of inquiry and kindly questioned Arlene about the meaning of this proclamation. Experienced and very sensitive, she was able to curb her initial shock and her impulse to change the subject, comfort Arlene, deny Arlene’s perception of her face, or fully express her intense sadness. Within this safe environment, Arlene was finally more able to feel accepted.
Creating a safe haven: Incrementally, through the therapeutic relationship, previously unconscious unacceptable thoughts and feelings can be revealed, becoming conscious and available for exploration. A continuing process of experiencing and discussing, can lead to an understanding that acceptable behavior does not always have to include compliance.

Long-term psychodynamic therapy: It is vital to recognize that this work can be very long term, sometimes on an as needed basis, as patients reach new developmental stages. The consistency of a therapist who can be available through the years is invaluable, although rare. In some cases psychoanalysis, a treatment process similar to psychotherapy but more intense, can be productive. In others, psychodynamic psychotherapy will be of great value (Lott, 1970; Sinason, 1992). The use of traditional analytic methods (working with transference, countertransference, fantasy material, and focusing on making the unconscious conscious) may be sufficient.

Additional modalities: Using art, music, or writing as media of expression may be very helpful. L.A. GOAL, an organization providing activities and support for adults with developmental disabilities and their families, teaches members appropriate behavior while encouraging expression of their feelings through words, art and music. Stories and pictures in Disabled Fables (Behrwald, 2004), a wonderful collection of stories and paintings done by L.A. GOAL members, offers an excellent example. Each story and picture is accompanied by the artist’s explanation of his or her personal understanding of his or her cognitive differences. For example, Lisa discusses her beautiful painting of a crane who needed things to be perfect and then describes her feelings about her difficulty with self-esteem: “When I first started painting, I did not like anything that I painted. . . . I didn’t think my work was good enough. Now . . . I probably would be more accepting of it.” (p. 39) Thus, talking about and normalizing feelings can be very important, both in individual therapy and in groups, where using prompts like stories and art can be helpful.

Sally is a very compromised thirty-five-year-old woman with Down’s syndrome, including many physical anomalies. Treatment modalities that were used with her included help with articulation and self expression, behavior modification, art and music. Aphasic when first brought to L A. GOAL, Sally had had little socialization experience and required close supervision and constant instruction. Staff made great efforts to help her with articulation, as they gave her instructions for appropriate behavior and support for listening and trying to respond. At one point, she was repeatedly running to the bathroom and unrolling the toilet paper. Repeatedly she was told, “Sally, do not unroll the toilet paper. That is inappropriate behavior and it makes me mad.” Months later staff were ecstatic when Sally yelled at a staff member, “I’m mad at you. I’m going to go unroll toilet paper!” She had learned to express feelings in words.
Specific Techniques: There are specific techniques for successful communication with this population of patients, whose attention span and ability to use abstract thinking are limited. People with cognitive disorders tend to speak and think concretely. Simple sentences or phrases can help them better understand and communicate successfully. Single-clause sentences, active verbs, and present tense should be used whenever possible (Prosser & Bromley, 1998). For example, Michelle’s family was puzzled at her defiance when they advised her that because of an income change, her counselor would help her with her “finances.” When her counselor explained, “There is less money in your bank since your roommate moved out. I’d like to help you figure out how much spending money you have each week,” she understood and felt helped.

Maintaining good eye contact while speaking is also important. This gives the patient the sense of being attended to and models good social skills; although some people, particularly people with Autism, may experience this as intrusive or over-stimulating. Usually, as the patient becomes more comfortable with the therapist, he or she will be able to tolerate more eye contact.

CONCLUSION

Shifting definitions of various disabilities, newer psychoanalytic thinking, and recent findings about certain disabilities have led to providing special-needs people with broader treatment options and support services. Adding psychodynamic treatment to the large number of support services that are necessary to assist special-needs people can greatly enhance their lives and those of their families. With the appropriate support, they now can live richer, more nuanced, and productive lives within their own communities.

This article describes unique therapeutic issues for families with special-needs members. These include mourning, recognizing that these disorder are chronic and not curable, and planning for a different kind of future than was hoped. Working with multiple agencies and/or services makes privacy and confidentiality difficult. Allowing special-needs clients to achieve as much independence as they are able to handle, and simultaneously providing the requisite amount of support and protection, is complicated. Focusing on transference and countertransference, considering the treatment relationship as primary, being empathic with what the patient is experiencing and using fantasy material can aid in the treatment of special-needs people. Sometimes utilizing art, music and writing can help these clients express inner needs.

Therapists must be patient, for change is slow and often minimal. Seeing progress is particularly rewarding, as is recognizing the immense efforts special-needs people make to overcome their unique challenges along with normal life difficulties. Therapists armed with knowledge of developmental disabilities, awareness of community services, and an ability to work psychodynamically are in a unique
position to help them attain more rewarding lives, lives that will be less constricted and emotionally richer - a rare and wonderful contribution!

Please contact the author for references.

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