

EXPANDING OUR EXPECTATIONS INDIVIDUAL AND GROUP COUNSELING AS EFFECTIVE THERAPY WITH PEOPLE WHO HAVE DISABILITIES

By Ginny Focht-New

Introduction

"It can't be done." "He's not therapy material."
"She's not counsellable." "That person doesn't
talk." "I don't know how to work with 'those'
people." The litany of rejections and negativity
goes on and on. Do you remember when we said
that people with a developmental disability could
not learn to dress themselves, feed themselves, go
to school and learn or live in a home in a neigh-
borhood? When considering either individual or
group therapy for people labeled with disabilities,
we once again hear disbelief get in the way of
creating opportunities and possibilities for people
we serve.

As this article developed I have struggled with the
terms, "people with" and "people without" disabili-
ties (intellectual, developmental, learning, etc.).
In my mind and in my therapy practice, I have
learned not to think in those terms. All people
have gifts and challenges. In therapy it is
important to suspend judgments and truly "be with"
the person in their struggles. Pairing up "people"
and "disabilities" is a form of diagnostic overshad-
owing, meaning that I cannot see the person
behind the word "disability," and if I cannot see the
person then I cannot help.

I do make many adjustments to the way I provide
therapy, according to the person's age, learning
style, emotional status, history of experiences, and
command of language, whether or not they have
the label of a disability. For the purposes of this
article, I have used disability language mainly for
those people who think it not possible to offer any
form of typical individual or group therapy to
someone with that label. However, it is not as
simple as saying that a particular type of therapy
helps people with disabilities as opposed to other
forms that can be effective with people without
that label.

Human service is a helping profession, and there
are many ways in which we can "help" people. The
true nature of helping is a mutual learning
experience, meaning that the helper also learns
from the assistance they give. Help is a continuum,
ranging from "I need you all the time" to "I don't
need you; I can do it myself." Helping begins with
caregivers and when it involves therapy, much
depends on whether or not those who provide
support think that a person can be assisted in that
way.

Those beliefs, combined with the power caregivers
possess, can create or obliterate opportunity. Our
goal should be to teach people to help themselves
by increasing their internal capacities and
resources, which can be accomplished in many
ways. The approaches I am discussing have a
similarity to other forms of therapy often used with
people who have disabilities, such as physical (PT),
occupational (OT), music or art, in that each is a
healing intervention that impacts a person on
many levels. This article is dedicated to considering
individual and/or group therapy as one way to help
people.

Developing as a Therapist

My development as a therapist began in 1972,
when I worked at a State Center, supporting people
who were very challenging to understand. During
this time I learned two things. One is that I had
much more in common with people with disabili-
ties than I thought. Secondly, most of the people I
worked with knew more than I gave them credit
for, and ultimately I learned a lot more from them
than they did from me.

In 1976, I worked as a nurse in a hospital with a
number of people who had had a stroke (another
form of disability). Each person's speech was
affected in various ways: some people had no

speech; some could only say a few words; and others struggled with saying words they didn't mean. I realized then that it was possible, even probable, that many people with "developmental disabilities" have "normal" intelligence, while trapped inside a body that does not work well, resulting in symptoms such as unclear speech and difficulty in processing information. Over the years, I have had experience after experience that makes me continue to believe that this is true.

In 1980, I returned to working in a residential agency with people labeled with disabilities, who also had very challenging behavior. During this time I was introduced to the ideas of gentle teaching and positive approaches, which continue to be integrated into the therapy I provide.

My thinking about therapy was impacted again in 1992 as I watched videotapes of family therapist Murray Bowen as he conducted couples therapy with a man and a woman, while two other couples observed. The couples watching reported that they learned a lot more when they observed than when they were in the therapy spotlight. This gave me the idea that people who are not very verbal are like most of us; we take what we can relate to from what a person says, and leave the rest. Talking back is helpful to the therapist but not always necessary to the individual receiving therapy. Many of us work through problems without ever talking to a therapist.

Then, in 1995, I was working in the position of assistant residential director at the same agency and it was often my job to support the teams to help the individuals we served. On one particular day, one caregiver after another talked to me about several men who were in a great deal of trouble, hurting themselves and other people. It occurred to me that these "challenging behaviors" were actually coping mechanisms. I remember finally saying, "This is ridiculous! We need to get these guys together in the same room and talk out what is the problem!" And so we did. We invited those who were considered to be the most

challenging people we served to participate in a group.

Based on the Murray Bowen approach of one couple working while the other two watched, we thought that we should include people who were in trouble and did not use many words, just to see what could happen. Staff were also asked to join us because, as a family therapist, I knew that any changes people make must be supported in their home and workplace by their "family" members. Sick and tired of dealing with the "us" and "them" attitude, we invited each person who was receiving or providing services with the understanding that we would all be equal members of the group, following the same rules, and participating in the same way. Of course this was a challenge, since it was not the norm for people with disabilities to be in group therapy or for caregivers to join as equal participants.

This was a support group with a therapeutic approach rather than a true therapy group. The difference is the depth in which individual issues are explored. A therapy group would expect members to share intimately personal details. The support group approach allowed for more flexibility in topics and less pressure for everyone to share really personal details. I worked with the agency's behavior specialist to co-facilitate the group. By having the person who is supported and the caregiver both participate in the group, they could work through a problem with the help of the therapist. They could also make use of a holistic approach, by continuing the process in the person's home, with the help of the behavior specialist.

An example of this process occurred one evening as we talked about violent actions, which was a common topic in the group. On this particular evening, hitting was the subject. First we asked each group member to say whether or not they had ever hit another person. Of course everyone with or without disabilities, said they had. Then we asked each person to describe when they hit

people and why. The next question was, "Has anyone stopped hitting, and if so, why and how?" Using this strategy in a group with people who have disabilities is different than in a typical support group. This is not because of people's disabilities but rather because they have had limited opportunity to compare their problems with people who don't have that label.

So, the idea was first to "normalize" the action of hitting by establishing common experiences. Secondly, we worked on understanding the "why" of the action without agreeing with or encouraging it. We wanted to help people to see that this action could stop. Next, people were asked how they stopped hitting, to offer a variety of solutions. Reasons why people had stopped included that they left high school, had become involved in a romantic relationship and/or they figured out other ways to deal with their anger such as talking or exercise. Staff sharing their own experiences and solutions to problems in a matter of fact manner was and continues to be very therapeutic. Finally, we asked those members with and without disabilities, who had not stopped hitting, what solution they thought would work for them outside of the group.

Remember that about a third of the group does not speak. This means that when we ask the question we may get a signed "yes" or a word from some, but for others, we do not expect an answer in the group. We do, however, look for changes outside of group, in the behavior of people who don't talk as well as in the people who are able to speak. The caregivers who are present in the group and the behavior specialist are the supports outside of the group. This strategy is not unlike that used in individual therapy. The main difference is that in the latter, the person and therapist sort through possible solutions and caregivers are not present to support the person when they go home. The therapist works with the person in the group to inform the caregivers.

It is critical for caregivers to participate in an equal way in a group and in a supportive way when a

person is in individual therapy. Beth Barol, Clinical Director, Office of Mental Retardation Statewide Training & Technical Assistance Initiative, speaks of caregivers as social therapists, who can provide loving, compassionate, and respectful understanding and support every day. The social therapist is like a therapist who provides individual or group therapy in that they both use a "power-with" orientation. The main difference is that the social therapist must also balance other responsibilities with the person such as maintaining physical health and skill building. Also, their counseling role is on a day-to-day basis, providing gentle guidance. The individual/group therapist focuses on and delves deeply into the complexities of the problem as the person experiences it, considering the whole person, without being responsible to the person day-to-day.

Tom was a member of our original Feelings Support Group. He was described as, "not therapy material," yet he was the most talkative person in the group, more so than those without disabilities who were participating. In fact, Tom was so talkative that we invented the "one minute rule." At the beginning of group sessions each member had one minute to talk about anything they wanted, and most of the time an "agenda" was developed from this activity. Members who did not speak or did not speak well still had a minute to communicate, to say the same thing over and over, or just be silent.

Waiting in silence was a challenge for the group. It was a technique to honor all members, slow us down, and teach us to listen to each other. Tom contributed by bringing problems common to other group members and sometimes he co-facilitated the group. In the second and third sessions, he confessed that he had hit someone prior to our getting together. After some exploration, we figured out that Tom thought he had to hit someone to be able to come to the group. Prior to future meetings, the caregiver was able to remind him that this was not necessary. Tom still hits people once in a while but he has made real progress in talking about his problems more frequently.

The Therapist

First and foremost, a therapist must be someone with whom the individual feels safe and comfortable. The best therapists are non-judgmental, experienced in a therapeutic model that matches the person's needs/diagnoses, know their clinical limits and listen more than they talk. Note that I did not mention the necessity of having experience with developmental disabilities. It is up to caregivers to help the therapist understand the individual's unique needs and means of communication.

The therapist assists people to work on issues they choose, helping them focus on issues that bother them, while also guiding them to work on areas they want to avoid. The most sensitive therapists will allow individuals to have as much control over the sessions (timing, topics, tempo, etc.) as possible, in order to develop a therapeutic relationship that does not repeat patterns that have hurt the person. People want a therapist who is skilled at working with their problems, while accepting them as people.

Cathy and I began working together in individual therapy. She is a person who has many words to use, but has difficulty in processing information. It can take a minute or more for her to consider and express her answer to a question. Cathy has experienced great loss in her life: her mother has a debilitating condition, and as a result, her father left her mother. Cathy's grandparents then cared for her. It was a difficult experience when her grandfather died, but it was devastating when her grandmother passed away a few years later. When we began to work together, Cathy was clear that she wanted to meet with me but didn't want to talk about anything that made her feel sad. If she even thought about someone else's loss she would well up with tears and refuse to talk. What is a therapist to do?

First we established that Cathy's story and her feelings are her own and that she never had to talk about anything she didn't want to. In the

meantime I suggested that we read a book together, *Help For The Hard Times: Getting Through Loss*.¹ It took a year to finish the book, but in the process we were able to make a list of what was true for Cathy. She learned to say what feelings she experienced and agreed that she was afraid of her feelings. She really identified with what the author referred to as the "loss pot," where all uncomfortable feelings accumulate when they are not expressed, until the lid explodes off the pot. A couple of months ago we presented a workshop on grief and loss together to a group of people she knows, some who have developmental disabilities and some who do not. This was a freeing experience for Cathy. In the workshop she talked about what happens when we stuff our feelings in the "loss pot."

Since that time Cathy and I have moved into using Eye Movement Desensitization and Reprocessing (EMDR)² to begin addressing the overwhelming emotions related to her loss and other, even more traumatic experiences. Once again we are on uneven terrain, learning a new way of working together. I must constantly check to see if she truly understands what we are talking about. Quite often she does not, but I see this as my problem, not hers. We are making progress together. Cathy has taught me much in the past year about people who have trouble owning their feelings.

Meaningful Therapy

People seek a therapist for many reasons. Frequently they believe that a therapist will tell them what to do about a problem, or their family or friends want them to go to fix some problem that gets on their (the family/friend's) nerves. There are so many times when caregivers will ask me to "straighten out" an individual and "make them stop!" This completely ignores what might be bothering the person. My other experience is that people are afraid to go to a therapist because they think they will be told that everything is their fault or that something is wrong with them.

Usually, I begin a session by explaining that I will not force the person to come and see me. Then I explain what we might do and how that could impact them. At the end of the first two to three sessions, depending on how nervous the person is, I will ask them if they plan to come back. This is something I do with everyone, regardless of his or her age, diagnosis, or disability. Developing a therapeutic relationship is not faster or slower based on whether or not someone has a disability. It depends completely on the person's past relationships and traumatic experiences. However, many people who rely on the service system have been taught to be "compliant" and I must make adjustments for this by helping them to truly make their own choices, rather than worry about what I want them to do. Of course, this may also arise, to some degree, with people who do not receive services.

What happens in therapy with all people is a dance, where the partners take turns leading and following. The person needs to choose what to focus on, while the therapist listens and learns. Then the therapist will lead the person in a direction of self-awareness. From the beginning, the therapist must create a therapeutic relationship that fosters safety, trust, and honesty. The therapist's role is, at first, mainly to listen and "be with" the person. These active "inactions" are part of an evaluation phase and contribute most to a solid foundation for the person and the therapist to work together. It means that I must be truly attentive to the person during the session, whether people are verbal or not. This was a challenge for me in the beginning because I did not know what to do with silence. I have learned that it may mean being more verbal if the person doesn't talk, using other forms of communication such as photos, picture cards, emotion faces, or role-play. A person's learning style (visual, listening, doing, or a combination) is what directs my approach.

I find that giving people as much choice and control as possible is another facet of developing

and maintaining a therapeutic relationship. From the first moment I meet someone, I begin to recognize strengths and build skills with the person. Eventually these abilities are used as examples of what has been accomplished and what can motivate them and build their faith to tackle new problems. The individual is the expert when it comes to his or her problem. As confidence in practicing new skills and emotions increases, the ineffective and unhealthy coping strategies quietly begin to go away. Sound familiar? It is! Remember positive approaches!

As time progresses and I have learned as much as I can about the person and how various situations are handled, I will ask more questions or make non-judgmental suggestions about various ideas that can be chosen. My goal is to help the person see that he or she has problems in common with many people (especially people who do not have disabilities) so they do not feel so alone. I also work to help the person see how their actions today may be a result of past experiences and that some of those actions are not needed in their present life. Then we can explore a myriad of solutions, both negative and positive, to gain insight into potential consequences of each possible answer. The person can pick and choose actions to keep or relinquish, and I will subtly provide education along the way.

When necessary, the individual and I will work on whom to include in the process of making change. Using a family systems approach, I have learned that when making a change in our behavior we transform the role we have in relationship to others. Transforming our role makes us unfamiliar to ourselves at first, requiring practice even to embrace feelings such as happiness or comfort. Others affected by our change may, without awareness, not support that growth. When I am able to include key people, they become partners with the person as they transform.

Joseph can speak, but not very clearly. He mumbles a lot or talks so fast that it is not possible

to understand more than a couple words he is trying to say. One week he came to the Problem Solving Group after an appointment with his psychiatrist, who said that Joseph was having a rapid heart beat as a side effect to one of his medications. Joseph kept saying that he was not going to go to sleep anymore. It took quite a while, many questions, and the help of a caregiver who is a group member, to figure out that Joseph's grandmother had died in her sleep of a heart attack. Once we helped Joseph understand that his heart condition was different from his grandmother's and that her death was not related to her sleeping, he said he felt much better.

I believe that working with people who talk can be as challenging as working with people who do not. It is easy to confuse the real problem by using many words. People who have only a few words do their best to make those words count. The bottom line is that what you verbalize has little to do with what you understand and that each of us takes from any life experience what we need, what we can relate to and understand, and then leaves the rest.

When a Person Might Seek Therapy

First and foremost, people should consider therapy when they choose to, or at least when they have agreed to check it out. This is a simple concept. People who do not want to work with a therapist will not come to sessions or will not participate while they are there. People might seek therapy when they have talked about a problem over and over with family, friends, or caregivers and can't quite come up with a permanent solution, when their friends, family, or caregivers cannot listen anymore, when a topic is so personal that it feels unsafe for people they know well to be aware of the details, and/or when a certain level of clinical expertise is needed.

When I worked at a counseling center with people who do not have disabilities, only about half of the people who scheduled an appointment showed up. My guess is that they were afraid a

therapist would point out all of their faults or just blame them for the problems they had. About half of the people who did come, dropped out after only a few sessions. The main reason seemed to be that while it felt better initially to talk to someone, there is then the realization that they may have to change and that is difficult for many people.

When working with people who receive support, dropping out can occur because they do not have a consistent ride to their appointments, or they do not drop out because they don't have much choice about going. I work hard to feel certain that people who see me really want to. This is hard when the "compliance" factor is used to invoke, "You must go to your therapy appointment!" Indications that people do not want to meet with me are when they won't talk, when they don't talk about anything substantial, when they never take off their jackets, or they simply tell me that they don't want to be there.

Actually locating a therapist may be a challenge. Remember that the goal is to find a therapist who is an expert on the problem and you, the caregiver, can help the therapist to understand the person. If the person has health insurance, you want to begin there. When the recommended therapist won't or can't meet with the individual, the health insurance company needs to know. They are responsible to provide a therapist, even if it means going out of network.

Working on Issues

The main reason people meet with a therapist is because of a disruption in their existing relationships, and this is true for people with and without the label of a disability. The topics that come up most often in both individual and group therapy are personal problems. They often include: getting along with caregivers and house/roommates; traumatic experiences from the past or present (real or perceived); grief and loss (especially about separation from family, as well as death); develop-

mental struggles (e.g., adolescence, having or not having children, etc.); symptoms of mental illness (depression, anxiety, post traumatic stress disorder [PTSD]; and/or autism or change of any sort [e.g., moving, housemates, job, caregivers]).

When I first meet with a person, we talk about what is bothering him or her, which is not usually the same as what is bothering other people in the person's life. So we begin with what is upsetting the person and then move toward how the problem affects other people. Relationship issues, which are common to the majority of problems, are most effectively solved when the other person involved in the problem is included. Exceptions to this approach occur when the individual does not want anyone else present or if meeting with others will recreate a traumatic experience.

Susan is a woman in her early forties. She resides in an intentional community where people with and without developmental disabilities live and work together. The reason we began to develop an individual therapeutic relationship is that a worker had sexually assaulted her. In the course of about eight months, we struggled with the issue and the manner in which Susan interpreted the experience, because she has Asperger's syndrome. Once we began the odyssey of working together we discovered that she was also very upset that her mother had died, that she had problems with the woman responsible for her home and that her day-to-day struggles could also be worrisome.

We handled each issue through the same process. First, we made sense of what Susan thought was the main problem. Then we established what certain words meant, such as sad and angry. Susan is someone who reads European literature so she relates what she thinks and feels to those books. Fortunately for me, she also has a few movies with which I am familiar, such as *Little Women* and *Out of Africa*, and we used these to create a common understanding. Next, we searched for examples of times when she had handled her thoughts, feelings, and actions in similar situations. We

repeated this process at least once and sometimes as many as four or five times in a session, as well as session after session. My responses were: "Yes, this happened. How did you feel? What did you do that helped? What would you do now if it happened?" and so on, over and over. This was necessary to respect her Asperger's symptoms and helped her to develop a problem solving strategy. More important for Susan was that we also practiced recognizing her skills and strengths and created a "letting go" strategy. Susan was vulnerable to becoming stuck in her thinking. It takes quite a bit of practice to change patterns of thinking, feeling, and actions, whether you have a disability or not.

Progress in Therapy

Recognizing progress is always a struggle between my own expectations and those of the person with whom I am working. I continue to practice letting go of my expectations because it is how the person feels that is most important. When I am not sure if someone is benefiting from therapy, I will sit back and use my observation and listening skills. I have become much more comfortable realizing that I don't always know what progress the person is making from session to session. When I can make a conscious effort to let go of the changes I think a person should make, I am much more able to help them and see progress from their point of view.

Most of the time I look for small steps such as the person coming to each session, arriving on time, participating, and "saying" that it helps. Whether people use words or not, I also pay careful attention to any change in my feelings, because I have learned that I may be picking up on that person's emotional reaction. People who don't talk can show progress though facial expressions, body language, and actions outside of the session that are communicated to me by caregivers. When obtaining information from caregivers, I always ask permission from the individual. Also, I do not speak about what the person says to me, specifically, during therapy. This is a matter of confiden-

tiality. Relying on what others observe is something I do when working with couples and families but not individuals, which is a difference from working with people with disabilities who have caregivers.

Dave is a person who speaks with very few words and only with great encouragement. He has significant autistic characteristics. Dave joined the Feelings Support Group with his housemates, and at each meeting he would sit in a chair away from the group. The first time we knew Dave wanted to be in the group, we invited him to sit with us (for about the fiftieth time) and he got up and sat at the table. He would sometimes sign "yes" or "no," but mostly he repeated words when asked questions. Often, when we would ask the group a question, Dave would take his turn but wouldn't answer what was asked. This time, when it was his turn, I asked the group to wait in silence. We waited several minutes (very painfully for some group members) before Dave answered the question, using most of a sentence that was clearly related to the question asked. All along we had asked questions but had never given Dave enough time to answer, or we would ask one question, then another and another, so by the time he was ready to respond to the first one, he was totally confused. Dave taught us to be patient.

Joyce is a very articulate young woman in her twenties. She asked to meet with a therapist individually, to work on her "compulsive issues." Joyce lives her life in a body that has cerebral palsy. In the beginning, it was difficult to understand what she said. As a therapist, I must take responsibility to understand what a person is trying to communicate. Joyce is a very organized person so we agree on an agenda of topics at the beginning and end of each session. At first she decided on five topics per session and also placed limits within the topics discussed. We write a "report" together at the end of each month to reflect on what has progressed. This is limited to five lines. I knew we were making progress when the "limits" loosened up. Sometimes we would

cover six or more problems or spend more time on fewer issues. It took about three months to make this progress.

The progress a person achieves is relative to the complexity of the problem and the person's commitment to solve it. I find it is best to measure progress in small steps, looking for both a decrease in the problem and an increase in healthier actions or coping mechanisms. For example, if there is a housemate issue, then we move forward when the person is able to agree that they can change their own reaction to the housemate. Progress is furthered when the person is willing to meet with the housemate to "talk it out," or better yet, to talk between sessions.

When people experience similar situations over and over, it takes more time to develop and practice solutions. I am very hopeful that this will change as I become more competent in using EMDR. This form of therapy puts the solution and healing thoughts and feelings in the hands of the individual, requires little verbalization and is proven through research to work well with people who have had traumatic experiences.

Group Versus Individual Therapy

I like group work because there is a richness of topics, common experiences, issues and solutions. Group therapy allows for the integration of people who do and do not have disability labels, and including people with limited language works well. However, the therapist must be careful to help members to involve everyone in the group discussions. This means assisting some people to communicate more and others to slow down. Another challenge can be the lack of agreement by caregivers to participate in a truly equal manner.

In both individual and group therapy, the people establish agreements about working together, which contribute to the success of the therapeutic process. In a group (with the help of the therapist), members establish group agreements

that apply to everyone. Some of our group agreements include:

- ◆ Confidentiality. We may not speak about what anyone says in the group to anyone outside of the group. However, members may talk about what they said in the group to anyone they wish.
- ◆ One person speaks at a time.
- ◆ No cursing.
- ◆ No hitting (Tom's rule).
- ◆ No eating or drinking (a distraction).
- ◆ People may answer questions or not; if not, we may ask "why?"
- ◆ If someone is upset the member is encouraged to say so (group members have done this) and may leave if the person chooses to do so (this has not yet happened).

Individual therapy works better for those who are not comfortable with many people and who may have experiences to work through that make them feel very vulnerable. Meeting individually maximizes the building of a therapeutic relationship and minimizes competition. I find that people who are less verbal sometimes do better with shorter session times, such as thirty minutes. The agreements in individual therapy are the same as in group therapy. For people who don't talk much, we establish what they might say or do if they do not agree, or do not want to address certain issues.

Which works better? It really depends on the person and the problem. Unfortunately, it may also depend too much on the comfort level of the therapist.

Length of Therapy

Therapy takes as long as it takes and it ends when the person says it is done. Occasionally, the therapist must make the decision to stop. I would end therapy if I reached the limit of my clinical skills. It is then my responsibility to refer someone to another therapist who has the needed skill. More often I make the decision to end because the person has worked through issues and has

become dependent on therapy as a social event. This usually occurs when the individual does not have friends or good supports. In ending therapy, I must consider the frequency of experiences that have resulted in disrupted relationships and ultimately in feelings of abandonment. Maintaining clear boundaries and open recognition of the therapist's time-limited role are important. I work on emphasizing the progress the person makes in helping him or herself. Too many people have been taught to be dependent on their caregivers' opinions about how well they do. The only way to handle the conclusion of therapy is to talk about the end from the beginning.

It is also important to establish caregivers' expectations about how long therapy takes. Contrary to popular opinion, a therapist does not have magic. If it were as easy as telling the person to "stop it," a therapist wouldn't be required. Developing a therapeutic relationship can take a while because people don't have extensive language or understand the therapeutic process or what might happen when meeting with a therapist, who is essentially another stranger.

Terry is a man who does not speak very much. He regularly came to the original Feeling Support Group but his participation stopped when a caregiver resigned and Terry couldn't get a ride. Caregiver commitment is often critical to a person's success, even when the caregiver does not participate. Terry's main problems were threatening people, banging his head and hurting himself. Terry loved coming to the group; we could tell by the noises he made. After a long lapse in attending the group, staff said that Terry was having quite a bit of trouble because his brother had contacted him and they started going out together. Terry was happy about this but after each visit with the brother, Terry banged his head so hard that he needed stitches (Terry wears a helmet all the time). We invited Terry and a caregiver to join the group again. When he came, we asked group members, "How do you get along with your brothers and sisters?" People took turns

speaking about those relationships, and only one person out of 12 said he got along with all of his siblings all of the time. When we arrived at Terry again, we asked if what everyone said made sense to him. He indicated, "yes." His "yes" is not always really "yes," but Terry continued to visit with his brother and did not need stitches again, at least not for that reason.

Conclusion

How can we help someone use therapy as an option? First we must look carefully at ourselves. Is the person struggling with an issue that triggers emotions and thoughts in me or is beyond my ability to support? When there is an agency, have I exhausted those resources to help the person? Next, do I have any beliefs that will interfere with helping people labeled with disabilities to obtain therapy?

It is very important to me that people reading this article receive the message that anyone who chooses therapy can benefit from individual or group therapy. This article is not about possibility; this is happening! Tonight I met with the women's group and asked if we should continue. Not only will we continue, but also they came up with many new topics: GYN exams; anger; health issues; healing through laughter; relaxation; and living in the moment. Then I met with the Problem Solving Group. We "talked" about being angry, about getting scratched, and arranged for a person to have help talking to the person's housemate. Then we supported someone who was sad that it was the anniversary of the death of his mom and a friend. Next, we had an intense discussion about jealousy and how many people a person can like at one time. Finally, we heard from a person who won a silver medal in bowling and has celebrated five years of sobriety.

Everyone participated in some way. Tomorrow and the next evening, I will meet individually with four different people. One person will talk with a caregiver about their relationship. For the other three, I try to plan for each session but I never

know exactly what will come up. Over time, I have gained the faith that I can be flexible and that eventually we will work together through whatever comes along and develop a plan.

Do not give up! It can be done!

References

¹ Earl Hipp, 1995.

² www.emdria.org



Ginny Focht-New has an MA in Nursing from The University of Pennsylvania and is certified as both a Psychiatric Clinical Nurse Specialist and a Developmental Disabilities Nurse. Ginny is Director of Nursing with Philadelphia Coordinated Health Care and also does individual and family therapy, specializing in trauma. In 1998 she received the Lillian Sholtis Brunner Award from the Alumni Association, School of Nursing, University of Pennsylvania, for her work in facilitating integrated groups of people with and without developmental disabilities.