CLIENT-CENTERED THERAPY IN THE CARE OF THE MENTALLY HANDICAPPED

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ABSTRACT. Regarding the treatment of mentally handicapped persons, three approaches toward treatment are possible. The first approach involves influencing the relationship between ward personnel and mentally handicapped persons. The second approach is the therapeutic treatment of mentally handicapped persons by means of mediation therapy, which means that the therapist is responsible for starting up, administering, revising and supervising treatment, but that the treatment itself is administered by ward personnel, parents and/or other persons. This implicitly means that, in imitation of Rogers, I consider empathic understanding and empathic responding as an attitude as well as a skill that can be learned. The third approach is treatment of the mentally handicapped person administered by the psychotherapist. In the following, I wish to elaborate on these three approaches. My work with mentally handicapped clients follows in a client-centered, as well as, a behavior-therapeutic frame of reference, and I am an advocate of a combination of methods (see e.g., Peters, 1984, 1991, 1992 and 1999), I will hereby limit myself to the administration of client-centered practice in the treatment of these persons.

Working On the Relationship between Ward Personnel and the Mentally Handicapped Person

In earlier writings (Peters, 1981, 1984a & b, 1992, 1996) I noted that the psychologist/pedagogue who works in institutions for the mentally handicapped has to deal with two parties concerned, i.e., ward personnel and the mentally handicapped residents. Although it is not customary to discuss relationships between ward personnel and clients in an article about psychotherapy, these relationships are so inextricably interwoven in intramural care they that I would like to at least mention the subject. Residents' self-mutilatory behavior, serious outbursts of yelling, crying, chaotic behavior, and so forth cause ward personnel considerable difficulty managing relationships with mentally handicapped residents. Problems regarding acceptance and empathy are pervasive. Problems of the mentally handicapped in intramural care are frequently reported by ward personnel; the
frequent reporting itself becomes a problem. What is taken to be the behavior problem of the mentally handicapped resident often turns out to be (and is sometimes exclusively) a relationship problem between client and ward personnel. In intramural care the residential context is an essential part of treatment.

Approaching problem behaviors of mentally handicapped clients should primarily involve a focus on the relationship between client and ward personnel. In addition to my own preference for client-centered therapy, ward personnel usually highly value a client-centered approach; hence the approach is consistent with the values of the ward personnel most involved in day-to-day interaction with clients. Personnel appreciate feeling recognized, accepted and understood for the problems with which they are dealing. Moreover, the process facilitates their own insight into their emotions and behavior. This sometimes leads to even radical changes in their relationships with mentally handicapped residents. Client-centered therapy offers more frequent and more valuable opportunities for process-oriented interaction, and for facing one's fears, uncertainties, limitations and so forth.

Client Jo

In the following I present a short example of how I approach potential problems in the relationship between ward personnel and mentally handicapped persons (more elaborate examples can be found in Peters, 1981, 1984, 1986, 1992a & 1992b). First I will share a group leader's text in which he specifies his problems relating to a mentally handicapped woman. Then I will describe how such a problem can be approached.

Some weeks ago I liked Jo a lot. I had lots of fun with her and she enjoyed this very much. Then, at a certain point, she started to become more and more attached to me. She constantly walked behind me, watching my every move and demanding too much attention. She also started to cling to me, pull at me, etc. From that moment I cut the ties, primarily because she became more and more chaotic. I did this by talking to Jo (in her room) and by telling her what I thought of the situation. The outcome was nothing. Then, if she was very busy I would have her sit still for awhile and, if she didn't listen at all, send her to her room (with the door open). Through doing this, I achieved what I had wished to do, that Jo became far less attached to me, but she still remained chaotic and busy. At this point I look at Jo as follows: she is a wonderful girl, but I am now afraid to give her any attention because she will want too much from me. I also often get tired of her repeated questions for the same things and so she irritates me quite easily. I also believe that it is necessary to talk about a general approach to Jo so that her limits can be made clear to her. For me, personally, this doesn't have to result in definite agreements or a certain approach, because it might mean that she would lose the freedom which she has and in which she has grown (and in which we still have to let her grow); that would be a shame.

The problem the group leader has regarding the woman is made very clear. In my function as a counselor/consultant working explicitly from a client-centered point of view, I look primarily at their relationship. The mutual pleasure they had at first, having contact with
one another, and the change that came about because he felt his attention was monopolized can be discussed. Discussing and analyzing a situation when it concerns a written text is often made easier because after rereading or hearing their own text, the ward personnel often identifies where the relationship went awry. How I respond does not depend on whether I hear the story or read it beforehand. The most important thing is to listen and react with an empathic attitude... although the response must not necessarily be an empathic one. Wexler (1984) and Book (1987), among others, distinguish between empathy and empathic responding. Being able to intensely absorb and feel what the client tells you as if you yourself are the client (empathy), does not mean that this has to be followed by an empathic response (empathic responding). It is possible to summarize what has been said, to make concrete or confronting remarks, and so on (for a summary of possible client-centered interventions, see De Haas, 1980 & 1981).

In mediation therapy with the group leader in the above example, I responded empathically with, for example, "it strikes me that at first you enjoyed having contact with Jo, but later on you felt that she claimed too much of your attention." This left room for the group leader to explore in depth a) his ambivalent feelings towards the client, b) the manner in which he conversed with her, and c) his view of their relationship. Our discussions led to clarifying the relationship difficulties, demonstrated the value of a mediation process, and contributed toward a possible, specific treatment for the client. In clarifying ward personnel responses toward mentally handicapped persons I do not conclude abruptly following the discussion of a problematic response, but instead set a process of improvement into motion.

Therapeutic Treatment as Mediation Therapy

By mediation therapy I mean that form of treatment "whereby someone after being trained by an expert, tries to influence the problem behavior of another person" (Klijn, 1978). Although the therapist is responsible for starting up, administering, adjusting and supervising treatment, the treatment itself is administered by ward personnel, parents, and/or other persons. This way of practicing therapy is used far more frequently in behavior therapy than in client-centered psychotherapy, although Gordon (1970a, 1970b & 1979) with his "Parent Effectiveness Training" initiated it.

Education of Mediators

Empathic understanding and empathic responding are partly skills and partly attitudes which can be learned. Rogers states this as follows: "Therapists can learn, quite quickly, to be better, more sensitive listeners, more empathic. It is in part a skill as well as an attitude" (Rogers, 1977, p.11).

Besides training personnel to work in a client-centered way through on-the-job-training with the help of text analyses, I also provided refresher courses to qualified ward personnel. Following an introductory session in which the core conditions are discussed, a maximum of 15 students get together for one and one-half hours for 20 weeks. When the course starts we are in the second session. The training is conducted in two ways. First, two to three participants hold a recorded conversation for ten to fifteen minutes, after which the tape is played in small parts. The conversation is then analyzed for empathic listening and
responding, congruent expression, and acceptance. The contents of the conversation are totally decided on by those who hold the conversation, with the exception that no private problems are discussed. For instance, themes can be taken from the work situation; or the learning situation itself can be discussed. By including the learning situation as a part of the discussion, trainees are quickly confronted with personal discomfort letting conversations fall silent and hence monopolizing conversations by firing questions instead of listening. The manner of responding during a conversation is then discussed. Next, participants can hand in a written text describing their experiences or conversations with a colleague or a client, which are then discussed by the group.

Client Ann

Although client-centered mediational counseling is the basis for a better way of handling clients, it does not pretend to change ward staff into psychotherapists. However, these people can be involved, to some extent, in treating people in a better way. I would like to illustrate this with an example concerning a client named Ann. I will discuss some excerpts from a taped session in which Ann was again in a psychotic depression. During these periods she can be very distant; talk in turn about times in the present and past; and be verbally and physically aggressive which results in wild hitting motions, frightening group mates very much. She then also appears to hallucinate.

In joint consultation between the doctor, ward staff and myself, a decision was made to draw up a plan of action on four levels. First, a structured day program with concrete agreements on how to handle certain situations. Second, individual therapy based on the Pre-Therapy methods of Prouty (see Peters, 1999; Prouty 1990, 1994; Prouty & Cronwall, 1990; Prouty & Pietrzak 1988, Prouty, Pörtner & Van Werde, 1998; & Van Werde, 1990). Third, a medicinal treatment by giving Haldol. Fourth, those moments when Ann was more open to contact, if possible, would be used to discuss things that occupied her, and to attempt to organize her chaotic perception of life. This would be done by two group leaders, more or less taking turns, to guarantee continuity, and each conversation was to be recorded and shortly afterwards discussed with me. The group leaders' responses were analyzed and suggestions for follow-up conversations were given.

Regarding outcome of the several forms of treatment, the first obvious result was the spectacular effect of Haldol within a few days, so that after a few sessions with her I stopped Pre-Therapy. There was more than enough contact to make use of the more regular ways of having conversations. All other agreements were held, including the talks which were to be held with the group leaders. It was a period in which past and present alternated quite frequently, and structure-- and with that, security-- had to be passed from the outside. flashes from the past (even from when she was living at home) could be used to talk about things from the present. The following recorded excerpt has been edited to delimit the corrupted way in which the client speaks and which sometimes complicates understanding her. A is the client. G is the group leader.

| A    | Last night... ...I can't stand it here. |
| G    | You can't stand being here? |
A  No, I can't.
G  Don't you like the room?
A  Yes.
G  Where?
A  I can't live in number 10.
G  Pavilion 10?
A  Yes
G  You don't have to...
A  Here...
G  Pavilion 9.
A  Here pavilion 9.
G  You live here with us.
A  Here nothing left.
G  Don't you like it here anymore? No...where do you want to go?
A  How?
G  Where do you want to go?
A  I don't know.
G  You must think about it. You must let me know some time.

Ann indicates that she is not able to take something anymore. The group leader concretizes this, from her point of view, by assuming that the client does not like her room. If Ann's first remark was to be followed by a question, then an open one would have been more appropriate, e.g. "Can you tell me what you are not able to take?"

Apparently, Ann seems to go along with G's remark, but then the subject of pavilion 10 comes up. In those days she talked more frequently about whether or not she should live in Pavilion 10, but basically she needed to know that she did not have to leave her own residence. G is right in giving her the security that she doesn't have to leave Pavilion 9. Ann, however, is still left with an unsatisfied feeling that is revealed in her remark "Here nothing left." The group leader, in my opinion, switches to concretize this feeling too quickly, whereas the client is not yet ready to put her feelings into words. When the group leader asks "Don't you like it here anymore?," she has concretized something, not Ann. And when she asks "Where do you want to go?" she is looking for a solution, instead of looking clearly at what is no longer appealing. A and G fail to connect.

I would like to make an observation that responding empathically, or in any other way, to feelings of children with Pervasive Developmental Disorder or psychosis is frequently contraindicated, and may lead to decompensation or to other disastrous consequences. With these clients, a structured and predictable living/work environment is of primary importance. Structured conversations, and/or therapy forms directed towards taking action can be the appropriate method for recurring behavior problems. Albeit this caveat, during moments when intense emotions and fears are evidenced in the client, the most advisable response might be empathy, which can have a calming effect. Nevertheless, therapists should be aware that when intense emotional reactions have calmed, the conversation should continue in a more structured form, or it should be ended thus preventing a client's stereotypical repetition of the same remarks.
That the client Ann is preoccupied with the subject "living" is evidenced by the fact that it is brought up again in the second session. Previously a different topic had been discussed in the second session. As I indicated before, past and present are often intermingled and images from the past are used to talk about subjects which occupy her mind in the present. A group leader whom she once knew, and having lived in another Pavilion in the past (Pavilion 8), are seized upon to discuss the living situation now and the fact that she can no longer walk. Below is an illustration excerpted from the second session.

A  The Dina...
G  I don't know her.
A  I do know.
G  Yes? A long time ago...
A  Yes...
G  When you were still little?
A  Yes.
G  When you could still walk?
A  Yes.
G  Such a long time ago.
G  In Pavilion 8?
A  Yes.
G  With long hair?
A  With long hair.
G  And the walking legs...
A  No, no longer, too short, too short...in the past.
G  In the past, yes.
A  When it grew long.
G  Two plaits...
A  Yes.
G  On her back. I remember.
A  Yes.
A  "Harrieng" (the word cannot be understood, but probably the name of a group-mate is meant) must leave...No.
G  Who has to go?
A  Yes.
G  Who?
A  Must go to Pavilion 10.
G  Who must go to Pavilion 10?
   Silence.
A  Pavilion 10
G  Pavilion 10, yes.
A  I don't want to go to Pavilion 10. Not nice.
G  You don't have to go to Pavilion 10. You have to stay in Pavilion 9.
A  Stay Pavilion 9...I can't do without you, can I?
G  No, you can't, can you...this is your room, you may live here...all right? ...silly girl.
A  A moment of silence.
A I'm not leaving.
G You don't have to leave...you may live here...
A Stay here.
G You belong in house 2...
A House 2...
G With Tinie and Henneke, Marleen, Lenie, Jet and Marlaine...
A Yes.
G All together...you too...
A Me together too...
G Together with house 2.
A Yes.
G You belong with us.
A Yes.
G You don't have to live anywhere else...All right?

Ann opens this part of the conversation by mentioning the name of a group leader who had worked with her some years before. G does not realize this immediately and indicates that she does not know that person. Ann sticks to her remark and G asks her about it. What strikes one the most is that it is the leader who places the event very far back in time ("a long time ago;" "when you were little"). When the recording is discussed it becomes obvious that she does this because Ann's past often offers points of departure from which matters can be made more clear. She also confronts her with the fact that she can no longer walk ("when you could still walk"). This confrontation is by no means strange. Ann had mentioned a "walking mat" while talking about the layout of her room, although it is known that she will never be able to walk again. An agreement had previously been made to talk about the fact that she could no longer walk and to help her deal with this fact. However, one might question the timing of this response, an issue that is discussed while listening to the tape. Ann concretizes her past by mentioning Pavilion 8 where she had indeed lived several years ago. The leader makes the past even more concrete by naming two of Ann's characteristics. She used to have long hair and could then still walk. The last remark seems to trigger a defensive response when she says, "No, no longer, too short, too short....in the past."

In my opinion we see images from the past in chronological disorder. The image of Pavilion 8, as well as that of the leader Dina, are realistic. However, we know that Ann did not have this leader in Pavilion 8, but a few years ago in the present pavilion. G is right not to discuss the time differences (she has by now found out who Ann meant, as she indicates when discussing the tape). She names particular aspects of Ann ("two plaits...;" "on your back, I remember") from the period when she first came to live at the present pavilion, providing Ann with recognition and trust.

After that, a seemingly incoherent passage follows about Pavilion 10, wherein the group leader asks too directly about Ann's remarks. It is not until after the second period of silence has fallen, when she repeats Ann's remarks, that it becomes obvious that the latter is occupied with her fear to have to leave Pavilion 9. These are not only denied by the leader, but Ann also concretely and directly gets a confirmation that she can stay in her present ward.
This brings me to a more general observation about conversation therapies with Pervasive Developmental Disordered and psychotic clients. The incoherent thoughts, skipping from one subject to another, as well as delusional and hallucinatory conditions are, in general, intensified by questioning such clients. Repetition of what the client has said and naming characteristics which, in practice, correspond to the client's experiences give far more safety and rest. It seems as if a feeling of security is created in the relationship. Prouty in particular used this intentionally in words and gestures.

The Direct Treatment of Mentally Retarded Persons by the Therapist

In the above, I have referred to my manner of working with ward personnel and to the way in which they can assist during treatments. I also have direct contact with mentally handicapped persons. Although the Rogerian basic principles and skills are in effect, the same as with non-retarded persons, a number of aspects should be mentioned when dealing with the mentally retarded. I will make a number of introductory remarks before giving a short, practical example.

Some Introductory Remarks

With the non-retarded it is commonly accepted that there is a reasonable degree of speech and understanding present. With the mentally retarded, especially with the lower levels, speaking and understanding language are (largely) restricted. During contact, a number of points must be focused upon. Their limited verbal communication necessitates the use of simple vocabulary directed towards the idiom of the person spoken to. Paraphrasing should be used with restraint or not at all because of the risk of going beyond the client's understanding. If ones method includes asking questions, they should be formulated very concretely. The question as to whether a client thinks that her group-mates do not love her may already be too vague, and the word "group-mates" had better be replaced by proper names. Just as for the non-retarded, "why" questions should generally be avoided. "Why do you look so angry?" "Why don't you like to go to work?" and "Why were you so sad?" and other questions often asked in the community pose serious problems for the mentally retarded and the non-retarded. They tend to block the expression of feelings, for the non-retarded lead to rationalizations; and for the mentally retarded, lead to confusion and frustration. I have noticed how important it is for the mentally retarded to be given the message that answers or discussions are not always necessary. Furthermore, non-verbal behavior and voice intonations are very important.

Many people experience conversions with some mentally handicapped persons to be very difficult due to problems in understanding. If I do not succeed in understanding after several attempts, I stop asking as continuing results in friction and irritation. Saying honestly that one does not understand, being silent, occasionally mentioning someone's name, smiling and using other non-verbal signals are very important. This may result in an eruption of what is bothering someone. In some cases, together with the ward personnel, I have resorted to listening to recorded conversations with clients and having them clarified by them, in order to learn to understand the clients better. Moreover, this proved to be a good opportunity to scrutinize my own way of responding. Not being able to understand someone during therapy sessions often made me wonder what the client had said in reality, which can easily come into
conflict with empathic listening, because in that case you are rationalizing your own non-understanding.

With regard to the length of the sessions, I would like to point to the following. In general, this is considerably shorter than with the non-handicapped. Fifteen to twenty minutes is quite normal; a session lasting thirty minutes is relatively long. With some persons I have the impression that much has to do with not being used to discussing their feelings and experiences with someone else. I had a client once who called me at regular intervals to make an appointment. She was quite adept at expressing herself verbally. When she had to make choices or when changes took place in her life, she could become very emotional (expressing doubts whether she could handle changes, crying, etc.). During conversations she knew how to express, quite well, what was bothering her, but at the same time she was extremely bothered about whether I did not find it strange and especially whether I did not find her crying childish. Well, these are normal behavioral patterns and feelings which also happen to non-mentally retarded persons, but with her these feelings were bunched into 15 to 20 minutes and she indicated that this span of time was more than enough. Besides, I often had the impression that our conversation had really left her feeling relaxed. It is far more difficult with the mentally retarded than with normal persons to break down problems and to reflect on them together when the problem is no longer acute.

With reference to empathy, I would finally like to point out that empathic responding can sometimes be destructive for a person because that person can completely go mad as a result of thoughts, emotions, remarks, etc. (and I think this not only happens to mentally retarded persons). I am presently counseling a woman with clear Pervasive Developmental Disorders, which constitute a very compulsive perseverance of things from her past and can cause her to run down completely. She can repeat the same why-questions very quickly, talk about a feather dress from the past, etc. It has been agreed that a theme will be discussed clearly only once and that it will then be closed. It appears, however, that it occupies her in other ways, as if she is dealing with problems from her past. At such moments we give her every possibility to relive them and try to stay very close to her.

The Case of Michael

I will now discuss in more detail, a client treated by me. I wish to say something about diagnosing as well as the total treatment plan in which the community, the day activities and myself were participants. Michael is a 28 year old male who tested verbally a low-imbecile level, and performance-wise at a high imbecile, up to a low-mentally deficient level. Holding a conversation with him is possible, yet limited. For further diagnosis I perform extensive file research. All file records known (e.g. environmental reports, reports of external and internal psychological/pedagogical research, speech therapy reports, school-, ward- and therapy reports and reports from occupational therapy) were reviewed and entered into a chronological summary with conclusion. The conclusive file data showed that together with his mental retardedness Michael showed rather autistic behavior. Below is a list of some of Michael’s current and recent behavioral patterns

- Exhaustive nagging and whining.
- A strange guttural way of talking.
• Exchange of feelings, but in a compulsive manner; be nice, be angry, be a friend, etc. (as if it were obligatory).
• The use of catch-words; talking in a mechanical, robot-like way.
• When coping with frustrations, aggression sometimes leading to a form of self-mutilation requiring assistance with self-protection.
• Sits in room tensed up; appears to be dealing with all kinds of things in his experience.
• Occupied with fidgeting, cycling and other activities to exclusion of outer reality.
• Enormous fears directed toward objects.
• Fantasy and reality are intermingled.
• Can dance for hours even if his foot hurts...does not observe reality.
• When offered choices, does not know how to choose.
• Relationship with other people very bizarre; sometimes very affectionate.
• Reverses situations: If he has had a quarrel with C (his friend), then he will say that C is feeling bad.
• Needs security about how things will be handled.
• Rejects brother's partner; yet fears losing certain relationships.
• Expects others to cry when he cries.
• Stomachache is associated with being excited.
• Ambiguity in language cannot be coped with. A word has only one meaning in his vocabulary.
• Sometimes talks very loudly; and becomes increasingly louder.
• Highly occupied with arranging time and structuring. He cannot live with "maybe" or other ambiguity.
• Incoherent memory.
• Vents anger by tearing photographs, usually of loved ones; and then wants new copies immediately.
• Often becomes calm after a tantrum.

When we look at M's course in life, we can come to the conclusion that he belongs to the group of pervasive developmental children (PDD). His initially relatively strong autistic behavior, which occurred at an early age, has developed very much in a positive way. The severely withdrawn behavior, the enormous cognitive retardedness, the almost complete lack of the use of language, the often serious behavioral problems, etc., have shown an important, positive development. M's behavior still strikes one as bizarre. He can be fickle in contacts and moods, he has internal fears, problems with reality, which all in all shows the picture that has been described above.

Treatment

The complete treatment must be embedded in the overall living/work situation of the client. In intramural care, this is seldom an isolated portion of an occupant's total pattern of living. At least four aspects can be distinguished in a plan of treatment, now exemplified in the case of Michael. The first thing that should be looked at is the relationship between ward
personnel and client. As Michael's case shows, PDD clients demand much of the ward personnel. Ward personnel can unknowingly create difficulty for the PDD client. Because of lack of insight into and irritation experienced by the PDD client, ward personnel may express their frustrations, and thus exacerbate the PDD client's distress. Addressing ward personnel-client relationships is therefore essential. Insight into client experiences and awareness of self as a resource are provided. Secondly, a set living and work program is very essential to these clients, so that detailed agreements on this have to be made. Thirdly, agreements must be made regarding management of potentially aggressive behavior (e.g., towards fellow occupants or themselves, destroying articles and such). These agreements apply to everyone involved with the client-relatives, housemates, ward personnel, and so on. Fourthly, PDD children can become highly emotional in some fairly predictable situations—when confronted with sudden changes, when they feel misunderstood, when treated humorously, and when questioned intellectually and/or socially. If shouting out feelings is a common consequence, then talk therapy might be indicated, as it was with Michael. The therapy lasted for several years, interrupted by a number of periods of several months. Combined with the structure of a day program, moments for Michael to express strong emotion are necessary. Not doing so can result progressively in aggression, self-mutilation, destruction and so on, risking the use of unnecessarily heavy measures and medication.

Therapy began twice weekly—more if Michael was severely emotional. Conversations were characterized by his single-minded expressions. In a compulsive way, in very strong words, he could tell me that he had kicked someone who was angry with him, that he had been kicked, and that he had cried. Likewise, he can also communicate his being nice. Over time, after repetition, the emotional intensity diminishes. I repeat his words as concretely as possible, let him finish what he is saying, hardly ask questions, only "can you say something more about that?" or to that effect and seldom a "why" question. Appealing to his perception of things is not as helpful as simply allowing the emotion to be expressed. Focus on his perceptions is more likely to yield intense perseverations that serve no useful purpose. Below is an excerpt from a session wherein Michael is able to vent some emotions (see also, Peters, 1999, in press). M stands for Michael and T for therapist. The client talks intensely, clips his words and is, because of his articulation, often difficult to understand—especially for outsiders. In the following text I have not copied the corrupted pronunciation for greater ease of comprehension

Client Michael

M Andrea angry... and Annet angry... and Michael angry, Michael... look... no... Michael angry and Annet angry, Andrea angry, Tonneke angry, Bob angry, kicked... Bob... hurt.
T Yes...(after which M immediately continues with)
M Yes, difficult.
M Difficult.
T Was it difficult for you?
M Yes, Michael difficult.
T And then you kicked.
M Kicked, Michael cry.
The above excerpt from the first minutes of a session shows that despite repetitiveness, something is gradually added to his story. My interventions are very strongly directed towards repeating (parts of) his remarks, as I have noticed that he recognizes this. I am aware that my intonations do not become obvious from the above so that they might sound more business-like than they are. Slowly, the severity of his remarks becomes less and at the end of the session, M is even relatively calm.

The session was closed with relaxation exercises. I used these for a long period of time. The reasons are: 1) The client is hardly able to direct his thoughts to something else and can be very persevering; 2) Changing this to a "do-action" seems to simplify directing thoughts; 3) When the client is severely emotional, he is not open to relaxation exercises. He can relax more easily when the emotions are less severe. Also, I hoped that the client could be trained in such a way that when a feeling of tension appeared in the group he would go to his room to
do these exercises either of his own accord or by being told by the ward personnel. Although this was not achieved, he did manage to do exercises if the ward personnel joined him.
Relaxation exercises are frequently used with systematic desensitization procedures with mentally handicapped persons. Here the intention was to teach the client to relax better after dealing with severe emotions, or to give him a way to deal with upcoming tensions.

My work with mentally handicapped clients follows a client-centered as well as behavior-therapeutic frame of reference. I am an advocate of a combination of methods. My opinion on how to use methods coming from different therapeutic backgrounds can be reviewed in previous works. The present article has focused on a client-centered practice model with ward personnel and clients diagnosed with mental deficiencies. The mediation model presented here is one that has resulted in satisfying relationships between ward personnel, parents, clients and mental health staff.

REFERENCES


Personalia

Hans Peters finished his studies at the University of Nijmegen (The Netherlands) as an orthopedagogue in 1968. Since February 1999 he has been registered as a health care psychologist. For 32 years he worked in Saamvliet, an institution for the care of mentally handicapped people. He is a member of the Dutch and Belgium Association of Client-centered Therapy, the Dutch Association of Behavioral Therapy and of the World Council for Psychotherapy. He published many articles on psychotherapy with the mentally handicapped and three books, including Psychotherapie bij Geestelijk Gehandicapten (Psychotherapy with the mentally handicapped). He is editor-in-chief of the Tijdschrift Cliëntgerichte Psychotherapie (Journal of Client-centered Psychotherapy).

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