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A holistic approach to managing behavioral issues with persons with mental retardation in extended care facilities

Darrell Lilly

A HOLISTIC APPROACH TO MANAGING BEHAVIORAL ISSUES WITH PERSONS WITH MENTAL RETARDATION IN EXTENDED CARE FACILITIES

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DARRELL LILLY

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APPROVAL SHEET FOR THE MASTER'S THESIS

MASTER OF ARTS THESIS

OF

DARRELL LILLY

APPROVED:

Thesis Committee

Major Professor Roger Mooney
Roger Mooney, Ed.D

Patsy Wilkerson
Patsy Wilkerson, M.A.

Paul Wiese, Ph.D

Tammy Willis
Tammy Willis, M.A.

Stephen L. O'Keefe, Ph.D
Graduate Coordinator/Psychology

MARSHALL UNIVERSITY GRADUATE COLLEGE

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Month Day Year

as meeting the research requirements for the master's degree.

Advisor Roger P. Mooney

Department of Psychology

Ronald J. Deutsch

Dean of the Graduate College

Abstract

Providing long term care for individuals with mental retardation is one of the most difficult issues confronting mental health and extended care facilities. Inappropriate behaviors related to long term institutionalization present an exceptional challenge for those caring for persons with mental retardation. Applied Humanism emphasizes a holistic view of the person. It recognizes that encouragement, responsibility, the right of choice, and an understanding of human potential are important elements for helping mentally retarded persons develop socially appropriate behaviors. This study examined the principles of applied humanism in the management of inappropriate behaviors among mentally retarded persons in an extended care facility. The research is a follow-up study of an applied humanism model that was published in 1995. There were 10 females and 27 males, 5 with a diagnosis of moderate mental retardation and 32 with a diagnosis of severe mental retardation involved in the research. The subjects were residents in a state-operated long-term care facility. The results indicated a marked decline in the number of socially inappropriate behaviors which remained stable over an extended period of time. Implications for further research and people that provide care for the mentally retarded are discussed.

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A Holistic Approach To Managing Behavioral Issues With Persons With Mental Retardation In Extended Care Facilities

The closing of state facilities that provide long-term care and an aging population have lead to a significant increase in the population of elderly persons diagnosed with mental retardation in local nursing home facilities (Mooney, Mooney, & Cohernour, 1995). Deinstitutionalization was mandated with the passage of the Community Mental Health Centers Act of 1963 (Cullari, 1998). Although there are community based training facilities for persons with mental retardation, the phychosocial and medical needs characteristically seen in the aging population and the limited monetary resources often preclude training facilities from admitting these individuals (Quam, 1986). State and federal regulations mandate that facilities caring for persons with mental retardation provide specialized programing for these individuals (Mooney, Mooney, & Cohernour). Programming may be especially difficult due to socially inappropriate behaviors often associated with the long history of institutionalization. The purpose of this research was to evaluate the effectiveness of humanistic approaches with persons with mental retardation.

Research indicates that behavior modification or token systems are the most often techniques employed in programs caring for persons with mental retardation (Gardner, 1988; Smith, Buckwalter, & Albanese, 1990). There are multiple problems inherent in the use of the behavioral techniques in programs with mentally retarded persons in long-

term care facilities. First, the use of behavioral techniques often requires training and supervision. The nurse who is responsible for supervising the treatment is typically not trained in behavioral techniques. According to Krebs and Larson (1988), nursing training typically emphasizes a holistic approach to treatment. The holistic approach involves concepts such as wellness, patient education, and nursing process. Limited funding, inadequate staffing, poor supervision of direct care staff, and staff rotation and attrition often seen in these facilities make consistency and availability of staff trained in behavioral techniques unlikely (Myers, & Blake, 1984; Gardner, 1988). Perrin and Nirje (1985) stated that the behavioral techniques assume the person with mental retardation lacks the internal resources to control behavior and must rely on some type of external controls. This places the responsibility for shaping and reinforcing behavior on the nursing staff. The use of time-out or loss of privileges typically the consequence of the inappropriate behavior are left to the staff (Luce, Delquadri, & Hail, 1980). McGee, et al. (1987) stated that these techniques make behavioral change contingent on capitalizing on the inequality between the staff and the person The intent is on controlling behavior instead of teaching the skills, values, and knowledge the person needs to develop equitable relationships (Mooney, Mooney, & Cohernour).

Humanistic psychology focuses on the uniqueness of the person, the relevance of subjective experience, the right of choice, and the need for each person to achieve their potential (Chaplin, 1985). Maslow (as cited in Hall and Lindzey, 1978) and Rogers (as cited in Prochaska and Norcross, 1999) write that the person has an inherent tendency to value experiences that enhance life. According to Rogers, human nature is good and

people strive to realize their potential. In fulfilling these potentials Maslow felt that the movement is from within rather than shaped from without.

Hall (1992) stated that applied humanism can serve as a model for normalizing behavior. The model manages inappropriate behavior, and assists and supports less advantaged people in their efforts to develop equitable relationships. Care is individualized, yet provided by a standard methodology. The resident is seen from a biological, psychological, and sociological perspective. The philosophy of applied humanism manages behavior that fosters the development of egalitarian relationships by integrating six principles into all components of the program:

1. *No punishment.* Punishment is defined as anything one intentionally does to make the person feel humiliated, guilty, remorseful or fearful in an attempt to change the person's behavior and expresses the power of a personal authority (Hall, 1992).

2. *Ensuring success.* The person is valued for the socially appropriate behaviors he or she demonstrates and is provided with the structure, the support, and the recognition he or she needs to demonstrate these behaviors (Dreikers, & Soltz, 1964).

3. *Independent decision making.* One must be allowed to make decisions independently and then experience the natural consequences of the decision be they good or bad, for to deny the person with mental retardation his or her fair share of risk experiences is to further cripple his or her healthy living (Perske, 1972).

4. *Logical consequences.* The person experiences the logical consequences of how he or she behaves and accepts the relationship of his or her choices to what follows (Dreikurs, & Grey, 1968).

5. *Gentle interventions.* If the person engages in behavior that threatens health, safety, property or the rights of welfare of others one does only what is necessary to disrupt the behavior (Hall, 1992).

6. *Teaching for behavior change.* Teach the person to replace problem behavior with appropriate behavior by demonstrating empathy, identifying the underlying skill deficit, breaking the deficit into teachable components, and setting up positive learning experiences (Hall, 1992).

Hall (1992) stated that applied humanism consists of two constructs. The first construct delineates a normalizing, non-punitive approach for responding to inappropriate behavior. The staff only responds to behavior that endangers health, safety, or property or significantly imposes on others' rights. The second construct proactively promotes positive socially appropriate behavior. Rather than punishment or criticism, when socially inappropriate behavior occurs the person is offered an alternative socially appropriate behavior. Lewis, Hayes, and Lewis (1988) stated that the knowledge of alternatives enhances the development of problem solving skills and allows the person to learn self-control rather than relying on external control. Allowing the person more control increases morale and enhances the quality of life (Winger, Schermond, & Stewart, 1987).

The purpose of this study was to evaluate the impact of the principles of applied humanism on inappropriate behaviors of persons with mental retardation in long-term care facilities. The research is a follow-up study of the effectiveness of the model in working with persons with mental retardation. The initial study was published in 1995.

Method

Subjects

There were 10 females and 27 males, five with a diagnosis of moderate mental retardation and 32 with a diagnosis of severe mental retardation involved in the research. Based on the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (4th ed., 1994), moderate (IQ less than 55) and severe (IQ less than 40) mental retardation indicates significant sub average intellectual functioning and concurrent deficits in two or more areas of adaptive functioning. The patients were residents in a state-operated 180-bed long- term care facility located in southern West Virginia. Staffing for the unit where the 37 residents were placed typically consisted of one RN, one LPN and three aides. The average age was 68.

Inappropriate Behavior

The staff and residents identified the socially inappropriate behaviors and the socially appropriate behavior alternatives. The definition of inappropriate behavior was based on Halls' (1992) research. Socially inappropriate behaviors were described as those behaviors that endanger health, safety, or property or significantly impose on other's rights, or subjects the person to social embarrassment, harassment, or rejection. The behaviors were felt to reflect either a lack of knowing or the acquisition of inappropriate behaviors as a result of modeling stemming from the years of institutionalization rather than an expression of intrapsychic turmoil (Mooney, Mooney, & Cohernour, 1995). The behaviors were monitored by certified health service workers seven days a week, 24 hours a day over a 12-month period. No intensive staff training was provided. The focus

was on teaching socially appropriate behaviors by offering socially appropriate behavior alternatives and by modeling. When staff members resigned or were reassigned to other areas in the facility, new staff members were oriented to the list of socially appropriate and socially inappropriate behaviors.

Intervention

In the previous study public disrobing, public masturbation, sitting on the floor, physical aggression, grabbing or hugging others, eating inedibles, and pilfering were identified as socially inappropriate behaviors. The interventions were:

1. Persons who disrobed in public were covered with a sheet and were taken to their rooms and instructed to dress before returning to the living area. The staff assisted those who had skill deficits in dressing. In the mornings the client was given the choice of clothing and throughout the day told how nice they look in their clothing. People who disrobed in public were helped to dress and told to keep his/her self covered while around others. To avoid public embarrassment, the person was taken to the room and assisted with dressing. During the day the person was told they looked good in pants/dress, that color, etc. .

2. Persons masturbating in public were taken to their room and told masturbation is done in the privacy of one's own room.

3. Persons sitting on the floor were assisted to a chair and explained that people sit in chairs.

4. Those acting aggressively were initially instructed to "stop". According to Reighley (1983) often instructing the person to "stop" is a sufficient cue to motivate the person to

choose an alternative behavior. If the behavior continued the individual was escorted to his or her room and told to return to the living area when behavior was controlled (i.e., the absence of the aggressive behavior). If the person purposefully spilled liquids, threw food, or engaged in other destructive behavior the staff helped him or her clean the area and used the incident as a learning experience (i.e., use of a mop in cleaning the floor, the use of polish and a cloth in cleaning tables, etc.). Nondestructive but irresponsible behaviors were ignored for ignoring the behavior allowed the person to choose more effective behavior.

5. Those who grabbed or hugged inappropriately were to greet others with a handshake and on approaching the person the staff extended their hand.

6. Those who ate inedibles were required to spit the material into a paper towel and the staff explained that eating or chewing the substance might make him/her become ill or choke. The substance was then properly disposed of in the presence of the resident in the waste can. The individuals were given gum as an alternative to chewing inedibles.

7. Those who pilfered merely had to return the item to the original place. A large colored dot was placed on the facing of the door to his/her room to help him/her find his/her room. Some of the pilfering appeared to stem from the person being unable to locate his/her room from the hallway.

In the present analysis the interventions were essentially the same. However, further examination revealed that the definition for aggressive behavior had been expanded to include verbal aggressiveness along with physical aggressiveness. The rationale for expanding the definition was that aggressive behavior decreased so the definition was

revised. Initially, if the person verbally expressed aggression with curse words it was considered acceptable, however, as the number of aggressive behaviors dropped the focus was expanded to include verbally abusive statements.

Results

The number of socially inappropriate behaviors for the first four month period in 1995 are shown in Figure 1. The number of socially inappropriate behaviors for the last four months and the same four month period in 2000 are shown in Figure 2. The number of socially inappropriate behaviors in Figure 2 reflected a relatively consistent decrease from the base line figures for 1995. Public disrobing declined 58%, public masturbation decreased 84%, and eating inedibles was reduced by 94%. Sitting on the floor, grabbing/hugging, and pilfering were eliminated. Aggressive behavior exhibited a marked increase. Research indicated the increase was related specifically to the broadened definition of aggressive behavior rather than an actual increase in the behavior.

Discussion

The admission of persons with mental retardation can result in severe stress for the nursing staff in long-term care facilities. The staff is used to working with the physically disabled elderly. Long-term care facilities typically lack the staff and monetary resources to provide specialized training. The results suggest that the principles of applied humanism can effectively manage socially inappropriate behaviors among elderly persons with mental retardation. There was a significant decrease in the number of socially inappropriate behaviors and the decrease was maintained over time. Applied

Figure 1. Inappropriate behaviors for the first four months in 1995.

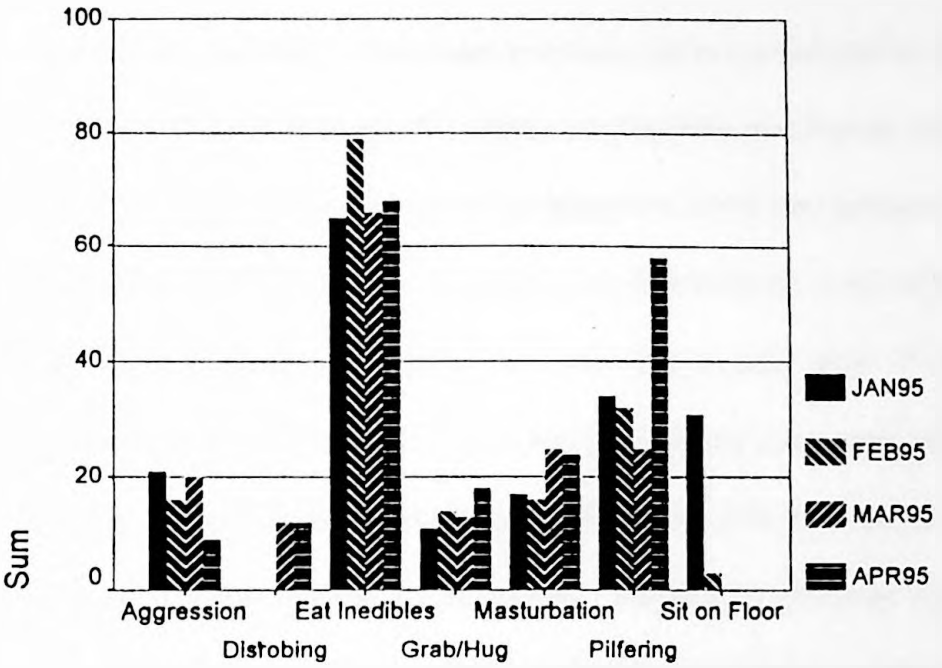
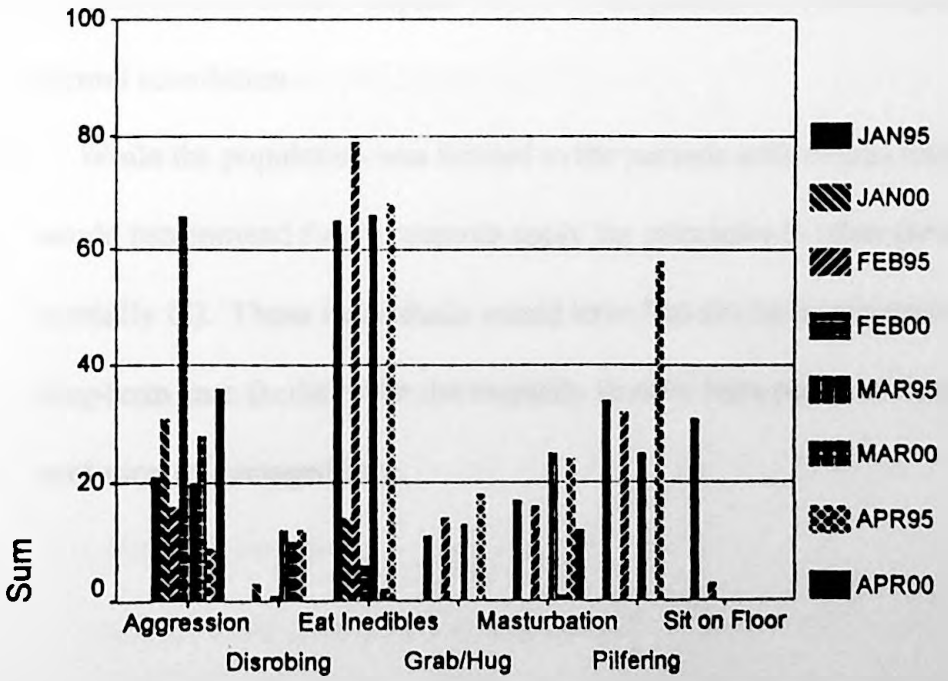


Figure 2. Comparison of inappropriate behaviors for 1995 and 2000.



humanism stresses encouragement, responsibility, decision making, and relationships. The principles are consistent with nursing theory and can serve as a guide for practice in long-term care facilities. Direct care providers can be encouraged to utilize life experiences to identify problems, implement solutions, and monitor efforts. The problems were defined as inappropriate behaviors rather than persons with mental retardation. The inappropriate behaviors were felt to be the result of the lack of learning or modeling of inappropriate behaviors rather than psychic stress. Emphasis was on teaching appropriate behaviors rather than extinguishing inappropriate behaviors. For the nurse, the techniques require little staff training. The staff and the residents gain new skills which enable them to act proactively. The process promotes a sense of control for the nursing staff which would enhance both job performance and job satisfaction.

For the elderly person with mental retardation, the acquisition of appropriate behavior is evidence of evolving adaptation to needs. The implications extend across professional boundaries and involve anyone who is in the position of providing care to persons with mental retardation.

While the population was limited to the persons with mental retardation the author would recommend future research apply the principles to other chronic populations (i.e. mentally ill). These individuals would have had similar experiences and the number of long-term care facilities for the mentally ill have been pretty much eliminated with the evolution of managed care.

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Appendix A

Review of the Literature

Humanistic psychology is a theoretical and therapeutic system of psychology that emphasizes a holistic point of view of human processes. Humanistic psychology focuses on the uniqueness of the person, the relevance of subjective experience, the right of choice, and the predisposition for each individual to seek to achieve their potential. Humanistic psychology evolved from the work of Abraham Maslow and Carl Rogers (Chaplin,1985, Hall, & Lindzey, 1978).

Maslow advocates a holistic-dynamic point of view that relies upon his research of healthy and creative people who have achieved their potentialities to the fullest. Maslow feels that psychology has focused excessively upon human weaknesses while neglecting human strengths. Psychology has "voluntarily restricted itself to only half of its rightful jurisdiction . . . the darker meaner half" (As cited in Hall, & Lindzey, 1978, p. 267). Maslow has attempted to present the other half of human nature, the hopeful, healthier half, and to give a better understanding of the whole person. According to Maslow there are three basic assumptions in his conception of the psychiatric healthy person.

> First and most important of all is the strong belief that man has an essential nature of his own, some skeleton of psychological structure that may be treated and discussed analogously with his physical structure, that has needs, capacities, and tendencies that are genetically based, some of which are characteristic of the whole human species, cutting across all cultural lines, and some of which are unique to the individual. These needs are on their face good or neutral rather than evil. Second there is involved the conception that full healthy and normal and desirable development

consists in actualizing this nature, in fulfilling these potentialities, and in developing into maturity along the lines that this hidden, covert, dimly seen nature dictates, growing from within rather than being shaped from without. Third, psychopathology in general results from the denial or the frustration or the twisting of man's essential nature. By this conception what is good? Anything that conduces to this desirable development in the direction of actualization of the inner nature of man. What is abnormal? Anything that frustrates or blocks or denies the essential nature of man. What is psychopathological? Anything that disturbs or frustrates or twists the course of self-actualization. What is psychotherapy or for that matter therapy of any kind? Any means of any kind that helps to restore the person to the path of self-actualization and of development along the lines that his inner nature dictates (Maslow, 1954, pp. 340-341).

Maslow later included another important basic assumption to the original three: This inner nature is not strong and overpowering and unmistakable like the instincts of animals. It is weak and delicate and subtle and easily overcome by habit, cultural pressure, and wrong attitudes toward it. Even though weak, it rarely disappears in the normal person, perhaps not even in the sick person. Even though denied, it persists underground forever pressing for actualization (Maslow, 1968, p.4).

Maslow proposed a theory of human motivation in which some needs took priority over others. He differentiated between basic needs and metaneeds. The basic needs were the physiological needs (hunger, affection , security, etc.). The metaneeds were the psychological needs (justice, goodness, beauty, order, unity, etc.). The basic needs are

considered stronger than the metaneeds and have been arranged hierarchically. The metaneeds have no hierarchical arrangement and one need may be substituted for one another (Hall & Lindzey,1978).

According to the hierarchy of needs, physiological needs such as food and water must first be met, then one is prompted to meet the need for safety, and then to meet the distinctive human need of love and self-esteem. At the top of the pyramid is the highest of human needs; self-actualization, in which one realizes their full and unique potential (Myers, 1999). The metaneeds are innate much like the basic needs and when the metaneeds are not achieved the individual develops pathologies (Myers, 1999).

Maslow developed the theory by examining healthful creative individuals that had in his opinion realized their full potentialities. He based the classification of self-actualization on people that were noteworthy for their accomplishments in life. These people shared certain characteristics that set them apart from others:

(1) They are realistically oriented. (2) They accept themselves, and other people and the natural world for what they are. (3) They have a great deal of spontaneity. (4)They are problem-centered rather than self-centered. (5) They have an air of detachment and a need for privacy. (6) They are autonomous and independent. (7) Their appreciation of people and things is fresh rather than stereotyped. (8) Most of them have had profound mystical or spiritual experiences although not necessarily religious in character. (9) They identify with mankind. (10) Their intimate relationships with a few specially loved people tend to be profound and deeply emotional rather than superficial. (11) Their values and attitudes are

democratic. (12) They do not confuse means with ends. (13) Their sense of humor is philosophical rather than hostile. (14) They have a great fund of creativeness. (15)They resist conformity to the culture. (16)They transcend the environment rather than just coping with it (Maslow, 1968, p. 176).

Maslow said that these attributes are possessed by those that have attained enough knowledge about life to be humane. These adults have resolved parental conflicts, found their purpose, attained enough bravery to be unpopular, and are unafraid to be decent. Those who have the potential to become self-actualizing adults are friendly, compassionate, and respectful of elders who deserved it. They are private about the cruelty, meanness, and mob attitude often seen in young people (Myers, 1999).

According to Rogers there is one basic motivational force, the tendency toward actualization. The actualizing tendency is "the inherent tendency of the organism to develop all it's capacities in ways which serve to maintain or enhance the organism" (Prochaska & Norcross, 1999, p. 136). Actualizing includes not only the tendency to meet the physiological needs (air, food, water, and to reduce tensions) but the drive to expand oneself through growth, and to enhance oneself through relating and reproducing.

A person is born with a valuing process that allows him to value positively those experiences perceived as enhancing life and valuing negatively those experiences that stifle growth. People are born with actualizing forces that motivate and with valuing processes that regulate. Rogers believed that human nature is good and that people strive to realize their potential (Rogers, 1951).

In Client Centered Therapy Rogers (1951) outlines 19 fundamental propositions that

characterize personality and behavior:

1. Every individual exists in a continually changing world of experience of which he is the center.

2. The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, "reality."

3. The organism reacts as an organized whole to this phenomenal field.

4. The organism has one basic tendency and striving - to actualize, maintain, and enhance the experiencing organism.

5. Behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived.

6. Emotion accompanies and in general facilitates goal-directed behavior, the kind of emotion being related to the seeking versus the consummatory aspects of the behavior, and the intensity of the emotion being related to the perceived significance of the behavior for the maintenance and enhancement of the organism.

7. The best vantage point for understanding behavior is from the internal frame of reference of the individual himself.

8. A portion of the total perceptual field gradually becomes differentiated as the self.

9. As a result of interaction with the environment, and particulary as a result of evaluational interaction with others, the structure of self is formed - an organized, fluid, but consistent conceptual pattern of perceptions of characteristics and relationships of the "I" or the "me," together with the values attached to these concepts

10. The values attached to experiences, and the values which are part of the self

structure, in some instances are values experienced directly by the organism, and in some instance are values introjected or taken over from others, but perceived in distorted fashion, as if they had been experienced directly.

11. As experiences occur in the life of the individual, they are either (a) symbolized, perceived, and organized into some relationship to the self, (b) ignored because there is no perceived relationship to the self-structure, or (c) denied symbolization or given a distorted symbolization because the experience is inconsistent with the structure of the self.

12. Most of the ways of behaving which are adopted by the organism are those which are consistent with the concept of self.

13. Behavior may, in some instances, be brought about by organic experiences and needs which have not been symbolized. Such behavior may be inconsistent with the structure of the self, but in such instances the behavior is not "owned" by the individual.

14. Psychological maladjustment exists when the organism denies to awareness significant sensory and visceral experiences which consequently are not symbolized and organized into the gestalt of the self-structure. When this situation exists, there is a basis for potential psychological tension.

15. Psychological adjustment exists when the concept of the self is such that all the sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of self.

16. Any experience which is inconsistent with the organization or structure of self

may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself.

17. Under certain conditions, involving primarily complete absence of any threat to the self-structure, experiences which are inconsistent with it may be perceived and examined, and the structure of self revised to assimilate and include such experiences.

18. When the individual perceives and accepts into one consistent and integrated system all his sensory and visceral experiences, then he is necessarily more understanding of others and is more accepting of others as separate individuals.

19. As the individual perceives and accepts into his self-structure more of his organic experiences, he finds that he is replacing his present value system based so largely upon introjections which have been distortedly symbolized -- with a continuing organismic valuing process (Rogers, 1951, p.483).

Rogers stated that clients enter treatment with the question; Who am I? Clients have a compulsion to get in touch with themselves, to understand themselves, and to become who they want to be. The basic goal of therapy is self-actualization. As a facet of the actualizing predisposition the client begins to actively differentiate; to see the difference between experiences that are part of one's own personal reality and functioning and those that belong to others. The individual experiences one possesses are self-experiences. The client becomes conscious of self-experiences by expressing the experiences verbally. The feeling of being alive and functioning is developed by the interaction with significant others (Prochaska & Norcross, 1999). Rogers stated that "our concept of self includes our perceptions of what are characteristic of 'I' or 'me,' our

perceptions of our relationships to others, and to the world, and the values attached to these perceptions" (Rogers,1959, p. 200).

As self consciousness evolves, one develops a need for positive regard for that self and the need to be accepted and loved. Positive regard from others, is overpowering and becomes the most profound need of the developing person. When others respond to a specific behavior with positive regard, the person's whole image of how positively he is appreciated or respected by the other is enhanced. The expression of negative regard by significant others, on the other hand, diminishes ones sense of how much he is loved. The demonstration of positive regard, however, by significant others is so strong that according to Rogers it becomes more important to the individual than the organismic valuing process.

One learns to regard himself in much the same way as he experiences regard from others. Learned self-regard leads to one viewing himself and his behavior in the same way as significant others. When one begins to act in accordance with the internalized values of others, he cannot regard himself positively as having worth unless he lives according to these conditions. The person feels good about himself, or lovable and worthy only when achieving, no matter what the cause. He may feel he has to be nice, be agreeable, and never say no to anyone (Prochaska & Norcross, 1999). According to Rogers, "If an individual should experience NO unconditional positive regard, then no conditions of worth would develop, self-regard would be unconditional, the needs for positive regard and self-regard would never be at variance with organismic evaluation and the individual would continue to be psychologically adjusted and would be fully

functioning " (Rogers, 1959, p.227).

The more conditional the love of parents for the child the more likely pathology is to develop. Because of the desire for self-regard, people begin to perceive experiences selectively. At an early age one begins to distort some of the values experienced and to perceive the values only in terms of their value to others. This falsification of oneself and experience is not the result of conscious choices to lie. As individuals live in a state of estrangement, experiences that are incongruent with the self are seen as threatening. Defense reactions are developed in order to prevent the threatening experiences from being represented in awareness. On the other hand, all use some defenses or symptoms to preserve self-regard and to prevent anxiety. While defenses help maintain self-regard, they do so at a price. Defenses result in inaccurate perceptions of reality due to the selective omission of information. Some individuals have such a significant degree of incongruence between the self and experience that rigid defenses prevent the person from functioning successfully and can lead to the disorganization of the personality. With the threat, individuals can be flooded with anxiety because the very concepts of themselves are threatened (Corsini,1984).

Rogers stated that achieving the major goal of client centered therapy is the inevitable result of providing a therapeutic environment where the necessary and sufficient conditions are present. These conditions are: 1. Two people in contact; 2. Incongruence on the part of the client; 3. Congruence on the part of the counselor; 4.The counselor's unconditional positive regard for the client; 5. The counselor's emphatic understanding of the client; and 6. The client's perception of the counselor's

unconditional positive regard and emphatic understanding (Prochaska,1999 p. 135).

These conditions create an environment where the person becomes free to express feelings. These expressions of feelings become more personal. As expressions of feelings increase more references to the incongruences of the experiences and the self-concept are observed . This incongruence is seen as a threat to the self by the client and is an impetus to change. The self-recognition of incongruence leads one to become aware of the feelings that have been denied or distorted. The client reorganizes the self to assimilate these previously denied or distorted feelings. With the continuing reorganization of the self, the self-concept becomes more congruent with experience. In addition, the client begins to experience more clearly the counselor's unconditional positive regard and develops an unconditional positive self-regard. The focus of evaluation becomes more internal, and the client reacts to experience more and more in terms of process rather than as a reflection of self-worth (Corsini,1984).

The processes of change in client centered therapy are conceptualized as a combination of consciousness raising and corrective emotional experiencing. The process involves empathy, congruence, and unconditional positive regard. In the process client-centered therapists emphasize the importance of the client's feelings. The therapists continued focus on "you really feel..." helps the person to become more aware of feelings. At the onset of therapy clients avoid emotional laden experiences. Clients tend to discuss emotional problems, as coming from outside themselves. Eventually, in response to accurate empathy and positive regard the person begins to describe the current feelings more fully. Eventually clients begin to express feelings of the moment.

The feelings are owned and accepted as originating from within the person and as worthy of positive regard. Rather than deny feelings, the person becomes more confident that emotions can be valued. The person starts to trust feelings and base more valuing on what they like or dislike, what makes them happy or sad, and what produces joy or anger. With the release and owning of emotional experiences, one begins to be in touch with the inherent organismic basis for valuing genuine feelings (Prochaska,1999).

At the onset the therapist's task is to allow the person to get in touch with the most basic feelings by demonstrating the attitude of unconditional positive regard. The therapist helps clients get in touch with and express threatening emotional experiences by continually redirecting the attention to the feeling aspect of what has been said. As the therapist empathetically reflects back to the client the essence of what the client is feeling , the client becomes able to attend to and feel the emotion and the meaning of experiences.

From a humanistic view inappropriate behavior is not the cause of people's malfunctions but the result of a fragmented life. The emphasis is on listening compassionately to the person in order to discover what organismic experiences are threatening to enter consciousness. The person-centered therapist accepts the possibility of the disrupting consequences of anxiety and moderates the flow of threatening emotional experiences (Wierzbricki, M., 1999).

Defense mechanisms used against anxiety-activating events by an individual are processed in such a way that supports the preserving of the person's self-concept. The distorted defense processes comprise the consolidation of new experiences into the

schema of the self. There is no allowance for the self-concept to accommodate these new experiences (Rice, 1995).

According to Prochaski and Norcross (1999) the problem is not that one can not live up to the concept of ones self, the problem is that ones concepts of one's self are too meager to let one be all that he was born to be. The solution lies not in increasing self-esteem but rather in expanding the conditions of worth. In therapy the troubled person is a victim in need of parental regard that has been too conditional and the responsible person is the actualizing person who moves from control by others and the environment, to inner control.

Rogers said that the natural actualization tendency brings people together rather than drawing them apart. He saw hostility as a way of obtaining respect from others. One may not express anger without feeling guilty or unworthy. According to Rogers, people who use hostility against others do so because of too little caring. The problem with communication is also a problem with caring rather than a language problem. Rogers said that a person can readily understand the real substance of what others say if he sincerely cares to listen (Prochaska, 1999).

Control becomes a problem when people attempt to force upon others their conditions of worth. To give up being controlled or to give up controlling, people must work to relinquish the inhibiting conditions of worth. Once a person is in the process of becoming more congruent, there is no inherent conflict between being an actualizer and being part of society. Attempts at bringing impulses under control through fancy techniques, produce short-term gain but little long-term maintenance, because the

techniques fail to focus on enhancing the natural abilities for self regulation. Rogers stated that meaning arises from the process of actualizing our tendencies to become all that we are intended to be. The source of meaning must come from within the person. The person needs to be the center of his or her meaning, rather than having a meaning being imposed by other individuals or society as a whole (Prochaska, 1999).

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