4-1977

"Branching from Within": A Program for Persons with Physical Disabilities

Nancy Belohlavek
Lindenwood College

"Branching From Within"

A Program for Persons with Physical Disabilities

Nancy Belohlavek

Faculty Sponsors: Dr. Joel Brende, M.D.
Isabelle Lewis, M.S.W.
Bill Bowen, ACSW

Faculty Administrator: Dr. Richard Rickert

April 1977

Submitted in partial fulfillment of
the requirements for the degree of
Master of Arts, Lindenwood Colleges

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INTRODUCTION

My graduate studies at Lindenwood 4 have focused on Social Work and Counseling theory. Practical application of the skills acquired was gained by developing a counseling program for individuals with physical or medical disabilities and coordinator of outpatient services for a community mental health facility. As a delegate to the White House Conference on Handicapped Individuals, I gained knowledge about legislative process and policy as well as further understanding the needs of handicapped individuals and their families. Details of the first and second trimesters work can be found in materials already turned in. The third trimesters work will include: the narrative transcript, papers listed in index, grant proposals, and a complete bibliography from all three trimesters.

All of the work I have done this year has been encouraged and inspired by my supervisors, co-director of the program, Jenny Ransom, and handicapped individual I have worked with as clients and those professionals involved with the White House Conference on Handicapped Individuals.

Our trips to Lindenwood 4 have been no more than monthly. However, Dr. Richard Rickert has given us good supervision and support in the development and continuation of Jenny and my studies.

Supervisors this year have included Bill Bowen, MSW, research and grant writing. Isabelle Lewis, MSW, social casework, and therapy with the disabilities clients. Dr. Stuart Twemlow, M.D., medical aspects of physical disabilities and administration. Dr. Joel Brende, M.D., clinical supervision for drug and alcohol clients, administration, and general therapeutic

techniques. Jenny Ransom, LBSW, M.A. candidate, guided imagery and Altered States of Consciousness.

In this year of study I have tried to include many of the same areas of study an MSW student might obtain. The advantages for me in a program like Lindenwood 4 was the practical daily experience of totally developing a new program, continuing clinical experience in the field of drug and alcohol abuse, administration of a community agency, and involvement with legislative process on a local, state and national basis. I feel that my weekly supervision, average of four hours, suggested reading have been fully equivalent to the experience most graduate social work students receive.

INTRODUCTION

The Lindenwood 4 graduate program has helped me focus on studies for an M.A. degree in social work and counseling. With the help of Nancy Belohlavek, Richard Rickert, and my supervisors: Isabelle Lewis, Pat Norris, and Bill Bowen, I have studied the development of a program for clients with physical disabilities. This has included reading and writing in the areas of clinical and administration. It has also included the operational aspects of the program, which began in August 1976.

This program has covered several different areas including:

I. Program Development: administration, research, and grant writing.

II. The Development of An Integrated Therapeutic Approach.

III. Relaxation, Guided Imagery, and Altered States of Consciousness Training.

IV. Continuing Education and Training Workshops.

V. Bibliography on three trimesters and on Altered States of Consciousness.

These five areas are described in the following pages written for my culminating project for Lindenwood 4 College.

I would like to thank all the people who have inspired and encouraged me during the past year. I feel I was very lucky to have such a fine variety of skilled professionals for teachers during this year of study.

For a more detailed summary account of my work refer to the Narrative Transcript.

Jenny Ransom

THE DEVELOPMENT OF THE PROGRAM: BRANCHING FROM WITHIN

Jenny Ransom and Nancy Belohlavek

DEVELOPMENT OF THE PROGRAM: BRANCHING FROM WITHIN

The past twelve months beginning in April of 1976 and ending April 1977, have been an unusually challenging time for us. In April of 1976 Nancy and I began both our graduate studies at Lindenwood 4 College and the development of our program for people with physical disabilities, "Branching From Within". Our goals were to get the program into operation and to learn a great deal about program development, administration, clinical outpatient therapy, the psychological aspects of physical disabilities, the development of a therapeutic approach towards clients with physical disabilities, the development of our own teaching abilities, and finally the development of our writing abilities. We accomplished all of these goals in varying degrees. Though we both worked closely together on these, we also had different emphases. I specialized in developing my clinical abilities while Nancy became more involved in the administration of not only our program but the whole agency, Suite 400. She worked with clients with drug and alcohol problems as well as clients with physical disabilities. I began working with adolescents with learning and emotional problems as well as clients with physical disabilities.

In conjunction with our Lindenwood 4 studies, we wrote up the work, in all of these areas, that we had done every trimester. The outlines and papers for each trimester explain our work in great detail. Rather than repeating that I will refer the interested reader to those specific papers.

During this time I worked as the house manager for a home for physically disabled young adults and Nancy worked on the White House Conference for Physical Disabilities.

We initially expected only to work with young and middle-aged adults. We began to get several referrals from the public health nurses and doctors in the community for people over sixty-five years of age, so we expanded our program until we had no age limit. We accepted people with all kinds of physical disabilities. Some of the disabilities we have seen in our clients include: multiple sclerosis; various types of cancer; heart and circulatory disorders; Parkinson's disease; cerebral palsy; and diabetes; just to mention a few. We have tried to keep our program open to all clients with physical disabilities who are seeking some help in adjusting to their disability.

Because of the variety of both ages and disabilities, we have several different approaches to our clients. We try to find the best form of therapy for each client. This is written up in the two papers preceding this one. Also, because of the variety of clients we see, there is no set length of treatment time that we can say we have decided upon. In general, we try to help the client develop his or her own strengths and work toward becoming as independent and self-confident as possible. We often begin seeing clients for two sessions a week and then as the client progresses in his or her therapy process, we gradually cut down the number of sessions that he or she sees us.

The first six months of our program seemed to go by very slowly for us.

We had very few clients and we were just beginning to be known in the community. We spent a lot of time seeking out referral sources by talking to groups of interested professionals, giving workshops, and giving radio public service announcements. The mental health agency, Suite 400, went through a very unstable period of time during the first six months of our program. This only made it much more difficult for Nancy and I to feel comfortable with the instability of both the agency and our new program. Fortunately, both the agency and our program stabilized after the first of the year. The combination of moving to a new office and the changing of several staff members of the mental health agency brought about the new stability and helped develop a staff unity. The agency then became more supportive of our program. The details of the problems of Suite 400 have been written up in a paper by Nancy. This can be found in our second trimester's listed papers.

The new stability of our program has increased our desires to both continue and expand it. We both have written grant proposals during our third trimester's work in hopes of securing future funding for our disabilities program and for Suite 400. These grants are listed and described at the end of this paper. We have also begun planning more educational workshops for both the staff at Suite 400 and the community on physical disabiilities. We are beginning to develop our own relaxation training tapes to use with our clients as well as in workshops. We gave a half an hour radio show on our program on March 28, 1977. We hope to continue to be involved with the media to educate the community as well as those with physical disabilities.

In summary, I suspect I could easily say that the problems involved in developing a new program were more than I had imagined. Being connected to a mental health agency has been both a help and a hindrance. We would have probably not gotten the community support as quickly if we had tried to develop our program in a private practice setting. The restrictions we have faced have centered around the time we have had to devote to the mental health agency that has not been related to our disabilities program and the low salaries we have been paid. Our future goals would be to become more independent as a program and perhaps to eventually expand into other cities. We also both have the goal of continuing our education on both clinical, administration, and teaching levels. We would like to continue to encourage both disabled and non-disabled individuals to learn to accept both themselves and others by developing their awareness of themselves and each other through self-exploration and self-inquiry.

ADMINISTRATION

HOW DIFFERENT IT LOOKS WHEN IT IS VIEWED AS AN AGENCY

The administrators of Suite 400 have always made it understood that I would be responsible, mutually with my co-worker, Jenny Ransom, for the administration of "Branching From Within".

In February of 1976, Jenny and I began fantasizing about a counseling program for handicapped persons. By April we felt comfortable enough with our relationship to accept the challenge of developing a program, "our program". Both of us brought complementary experience to the challenge of developing a new therapeutic approach to working with the disabled. Mutually, it was decided I would handle the administrative details of "our program" with all changes and implementations being jointly decided upon. I represented the administration of "Branching From Within" and its interests (i.e.: financial, special, and equipment), to the staff and to administration of Suite 400 (the outpatient mental health agency in which we are located). Included also was developing community support, interest and resources, gaining awareness of public policy, local, state and federal which affected the disabilities program.

In previous trimesters, Jenny and I have written the developmental process of "Branching From Within" and last trimester I presented a lengthy overview of Suite 400 including the make-up of the entire corporation. I refer any interested reader back to these papers, which included in detail

the problems "Branching From Within" was facing in the midst of an agency going through both internal and external turmoil.

In November of 1976 my position changed from therapist to Coordinator of Outpatient Services of Suite 400, making me responsible for the entire agency. As coordinator I am often making decisions which are not compatible with growth or desires of "Branching From Within".

In this paper I want to share the conflicts I faced while handling administrative policy for the agency in which "our program" is located. The social work literature on administration deals only with large burecratic systems and does not speak to administration of a small mental health agency.

I initially assumed the major conflict between program administration and agency administration would be time. In assessing the past six months, I find four major areas: funding, time, staff, and operational priorities which have caused conflict between program and agency administration. All areas are interrelated with funding directly affecting all of the areas.

Being a private non-profit agency, Suite 400 does not have the luxury of a yearly operating budget. Therefore, no program is allotted a specified amount of money per year. The agency views the three programs, drug and alcoholism, services to adolescents and their families, and disabilities counseling as a unit. The disabilities program is the only program still being viewed separately, which I attribute to Jenny's limited involvement with general clientele, and that the alcoholism, drug and adolescent counseling are very similar. The disabilities program is unique,

independently designed and implemented by only two staff members. It has been only in the past month that the entire Suite 400 staff has been exposed to the treatment modalities and goals of "Branching From Within". Because Jenny and I developed the concept of counseling for the disabled, we have a protective feeling about what we are doing and still view it as "our program". When "Branching From Within" began with the agency, it was "taken on", rather than, "taken into" the agency. Jenny and I were originally led to believe by the previous coordinator of Suite 400, that as the client demands rose, staff time, salary, and equipment would also increase. As an individual observing a specific program, it becomes easy to calculate numbers of clients, review the production, forgetting the total agency and its expenditure.

Financially this small agency resembles a family in which all working members' earnings are pooled together to meet their living expenses. The agency is made up of administrators, the parents of the family members, and staff. If any money remains the parents and when applicable family members decide on priorities which are then purchased one by one. Each family member generates a different amount of revenue which often varies monthly with client turnover and the clients' funding source. One family member may be supported by outside funds such as a grant. This is both an advantage and disadvantage for other members, as guidelines often regulate the types of clients this staff can see, leaving the responsibility of all other clients to remaining staff members. As in a family each person views herself or himself as an individual and their gains are very personal.

I have found this to be true of staff members, especially in a small agency where revenue (incoming and outgoing) is so easily observable. The staff feel they should be compensated in monetary terms for their individual contributions.

Locating funding sources for an agency such as Suite 400 is extremely difficult. Third party payments, insurance, medicare and medicaid in addition to fees for service do not meet operational costs. During the past six months, I have sought grants which the agency as well as "Branching From Within" would be eligible for. Drug abuse grants are easier to locate than grants for a disabilities program located outside of a medical setting. I have written a letter of inquiry and completed one grant application from the State Drug Abuse Unit. Together, Jenny and I have written letters of inquiry to foundations and agencies which might have monies available for disabilities programs. Because of the different emphasis, the Suite is unlikely to find a funding source which would be able to provide money to it as a unit. This perpetuates the separateness of the programswithin the agency. I have chosen to apply for money which was more likely to become a reality. I made a choice which was beneficial for the agency and if money becomes available for another staff position, it will affect the disabilities program in that the agency will have more revenue, but no direct advantages for the disabilities program will be noticed.

The grant is an example of the time element I face being directly involved with agency versus the specific program. My first priority must be the agency. This will in turn have an effect on the program. One way

that I have managed to free time for public relations in disabilities is to allocate responsibilities to other staff members for portions of Suite 400's programs. I represent the entire agency no matter whom I speak with. The only thing that changes in my presentation is the emphasis on relevant aspects of the program they are interested in. Presently the amount of time available for public relations has been limited. This has an influence on the disabilities program. It has been proven throughout this year that the more exposure Jenny and I were able to get within the medical community, the more referrals we would receive. There are still a couple of resources which need to be developed and I am presently unable to free necessary time to do so.

There are two other problems that I have to deal with in budgeting my time. The first is the number of administrative hours required to operate the overall agency which leaves working with most of the disabled clients to Jenny. It was decided for the coordinator to carry a quarter time caseload and three-quarter time for administration. Presently I am carrying half and half because there is not enough clinical staff to handle all of the referrals. The second problem is my time for direct treatment. My clinical time is not totally in working with disabled clients but indludes alcohol and drug abuse clients. Many of the disabled clients require home visits which add from 15 to 60 minutes per visit to the 50 minute session. This is not feasible for me when I'm trying to conserve time. As coordinator I have the responsibility of accepting clients for the total agency, including adolescents and drug and alcohol cases.

In an agency with only four full-time therapists, one part-time, and three part-time consultants, everyone must be versatile and autonomous. Specializing is not effective.

In hiring a new therapist recently, I felt a need to find someone with experience in a number of clinical areas. However, money dictated that a person with limited experience be hired. It is necessary to hire an individual who has some clinical experience, flexibility, and most importantly a willingness to learn. By hiring such an individual, I became aware of the number of hours required to train and supervise that person. There are advantages to hiring a person with limited clinical experience in that they do not have to be "untrained" before we train them in the techniques and styles of our agency.

Staff members do become known within the agency for their expertise and are encouraged to share knowledge and teach one another by working together on selected cases. A staff's expertise becomes a problem only when that is all they are interested in doing. This presents a conflict for the disabilities program. Jenny and I understand the importance of research into developing new treatment techniques for the disabilities and studying the psychological aspects of disabilities. However, this is specializing. From the agency's point of view, it is not financially feasible to pay someone to work with only selected clients and not be able to meet all the agency's needs. To justify a therapist seeing only one portion of the agency's clientele, it is necessary to have enough clients needing service in that particular area before paying the therapist for their work. If the caseload remains unstable, there is a real conflict and I am left with only

two options; first, paying the person only on the basis of hours per month, or secondly, having the therapist be willing to see other clients within the agency. Therefore, I am again faced with the decision of having to meet the needs of the agency rather than the disabilities program.

The fourth major area of conflict between program and agency administration is operational priorities. The conflict for me is that I cannot make any decision about setting operational priorities at the Suite unless I first take in account the needs of handicapped individuals. In doing so it creates more cost for the agency and as a result I have to compromise or be persistent and firm in seeing to it that the priorities incorporate the rights of the handicapped. As an agency, we cannot discriminate against any person because of race, religion, age or sex nor will we discriminate against handicapped individuals. Suite 400 as an agency would probably not be pressured to integrate if it were not for the disabilities program. The conflict arises in that the administration and staff are not sensitized to the barriers faced by the disabled and limited funds make dissolving architectual barriers difficult, and slow in becoming reality.

Last April when I began working with Jenny, I had many reservations about my future involvement with the disabilities program after completing my graduate study.

I had really enjoyed working in the field of drugs and alcohol abuse and with the penal systems. I was renewing my concentration in the area of disabilities at this point in my life because of my own disability. I was excited about the concept of what Jenny and I had proposed and decided to

make no decision until we had completed our masters. I still have made no decision about changing my clinical focus but what has happened is that I have become sensitized, excited and involved in the area of handicapped individuals.

Because of my involvement with disabilities both professionally and personally, it has become difficult to compromise administratively.

The reality of administration is that the overall needs of an agency have to take precedence over the needs of an individual program.

APPENDIX

for

How Different It Looks When It Is

Viewed As An Agency

Suite 400

a program of CAT.

SUITE 400 – JAYHAWK HOTEL
P. O. Box 58
Topeka, Kansas 66601
235-5306

January 20, 1977

Mark Brewer
Drug Abuse Unit
Biddle Bldg.--2nd Floor
2700 W. 6th
Topeka, Kansas 66606

Dear Mr. Brewer,

Suite 400 is writing this letter of interest requesting consideration of out-patient treatment money available through the National Institution of Drug Abuse, program 410.

Suite 400 is an out-patient clinic which provides services to persons struggling with problems surrounding chemical abuse, their family, or significant others.

Presently Suite 400 is involved not only with adults, but also adolescents. The adolescent population being seen has a high-risk chemical abuse potential in that the majority are presently involved with chemical usage or abuse, or their family members are.

Suite 400 is aware of clientele other than those presently being seen which could utilize our services, however, because most of these clients would be unfundable for various reasons, we do not seek them out. Fifty per cent of our clients (out of our total average load of 70) are funded by Title XIX medical cards, the other fifty per cent are insurance, (approximatley ten per cent) or paying on a sliding scale basis (forty per cent) which averages no more than $4.00 per hour. For this reason, Suite 400 is interested in securing alternate funding sources for those persons unable to pay even a nominal sliding scale fee.

Our present staff consists of four full-time counselors, all of whom have had experience in the drug abuse field and three consultants, one of whom is a psychiatrist. In replacing or adding staff, we will seek out persons with commensurate experience. All Suite 400 staff are involved with weekly supervision and are provided with regular inservice training programs.

The agency requirements and responsibilities have been explained to Suite 400, and we are willing to meet the federal funding criteria as

stated in the program guidelines, and are willing to continue the contract for the four year period and beyond.

If further, more detailed information is required, please feel free to contact me.

Sincerely,

Nancy Belohlavek, LBSW
Coordinator of Out-patient Services

NB/jg

SUITE 400 - PROGRAM PHILOSOPHY

Suite 400 was originally established as an outpatient clinic to provide services for people struggling with the problems surrounding alcohol or other drug use. We are currently a community mental health center capable of offering treatment to the broad spectrum of psychiatric difficulties. The basic philosophy behind the original establishment of Suite 400 was that there was no place for alcohol and drug treatment on an outpatient basis in the community. In keeping with that original philosophy, Suite 400 has now expanded the categories of problems it is willing to deal with and treatment, but we have selected either target populations or target problems for which treatment at other facilities in the city is non-existent. Suite 400 currently specializes in the following three areas: (1) alcohol and drug abuse treatment, (2) services to adolescents and their families, (3) mental health care for the physically disabled.

Program Philosophy

1. Alcohol and Drugs. The American society has a tendency to talk about the "drug problem" or the "alcohol problem". When this approach is taken, the concentration of efforts is placed on the drug being used. What must be kept in mind, however, is that no drug ever does anything to anybody until they take it. Here at Suite 400 the basic concept is that there is no drug problem only people problems. People may become addicted to certain substances or may tend to abuse certain substances, but it is not the substance which is important in any attempt to help those people regain control of their lives. Those same people might as readily be addicted to other people, activities, or things. For this reason the staff at Suite 400 believes that in any attempt to help our clients achieve the goals for which they come seeking assistance, we must first start with an exploration of them as people. Any treatment used must explore the whole person and an attempt to understand and satisfy the entire person's needs.

2. Service to Adolescents. There has been a large increase in the number of adolescent referrals (50% of our 60 referrals since January 1, 1977, are adolescent drug users or experimenters.) All of these adolescents are already having behavioral problems, a number of them because of their drug involvement. Approximately half of our adolescent referrals have already had contact with the juvenile court systems. Suite 400 tries to involve not only the individual but also the entire family in the treatment process. It has been found that the best success rate comes when the whole family changes and this often helps the family unite so that younger children may have a better chance of adjusting and dealing with family life and coping with developmental problems.

Individual counselors work closely, not only with families, but also with other agencies which are involved with the adolescent i.e. schools, foster homes, parole officers, etc. Therapy is also very individualized as adolescents do not seem to be as receptive to traditional psychotherapy. Suite 400 feels

the adolescent is a good population to focus our attention on as they are young and changes may be easier now than after a number of years of continued drug abuse which often leads to involvement with the law. Also, with focusing on their family, we hope to have some affect of prevention for the other family members.

3. Branching from Within. Branching from Within is a program for the physically handicapped or for people who carry a medical diagnosis which will require a radical altering in their current life style. The focus of this program is on assisting people in adapting to a new style of living, dealing with the feelings surrounding their loss or incapacitation, exploring new alternatives. In addition, affective guided imagery is used with some of the clients to teach relaxation techniques, etc. A positive feedback schedule is constructed to help patient's in maintaining the medical regime they are placed on by their own physician or attending nurse.

Consultation and referral to appropriate agencies are offered for all persons not considered appropriate for treatment at Suite 400. While Suite 400 operates on a basic clinical fee schedule, actual charges are computed on a client's ability to pay. No person will be denied services on the basis of race, creed, sex, inability to pay, or inability to participate during "normal office hours".

APPLICATION FOR GRANT

TO: DRUG ABUSE UNIT
2700 West Sixth
Biddle Building
Topeka, KS 66606
913-296-3925

1. APPLICANT: Suite 400
Legal Name of Organization

1319 Lincoln
Street Address

Topeka, Kansas 66604
City, County, Zip Code

11. PROJECT COST:

Requested from DAU 8,750
Grantee Contribution
CASH 1,875
INKIND 1,875
TOTAL GRANTEE 3,750
TOTAL PROJECT COST $12,500

12. FUNDING RATIO: 70 %FEDERA
30 %GRANTE

2. FEDERAL EMPLOYERS TAXPAYER I.D. # 48-0720564

3. TYPE OF ORGANIZATION: ____PUBLIC __x__PRIVATE NON-PROFIT ____PRIVATE PROFIT

4. SERVICE AREA: ____STATE __X__COUNTY ____OTHER (SPECIFY)
____REGION __X__CITY

POPULATION _____

5. TYPE OF PROPOSED PROJECT: ____PLANNING __x__TREATMENT ____EDUCATION ____TRAINING
____RESEARCH ____OTHER (SPECIFY)

6. TYPE OF APPLICATION: ____INITIAL __X__CONTINUATION

NUMBER OF GRANT TO BE CONTINUED I - 21 - 40965

7. PROJECT DIRECTOR: Nancy Belohlavek - Coordinator of Outpatient Services
NAME TITLE

1319 Lincoln, Topeka, Kansas
ADDRESS

235-5306
TELEPHONE

8. PROJECT FINANCIAL OFFICER: Glenn Leonardi - Executive Director
NAME

1319 Lincoln, Topeka, Kansas
ADDRESS

235-5306
TELEPHONE

SHORT TITLE AND BRIEF SUMMARY OF PROJECT: Drug Counselor. Provide for a full-time person to do intakes, provide on-going individual and group counseling for drug abusing clients, and provide family counseling when this is indicated. This person would also be available to work with other agencies, schools, etc. having questions regarding drug abuse.

10. DURATION OF PROJECT: One year

13. PROJECT DESCRIPTION - PLEASE STATE CLEARLY AND IN DETAIL, PRECISELY WHAT WILL BE DONE, WHO WILL BE INVOLVED AND WHAT IS EXPECTED TO RESULT.

I. PROBLEM
II. RESULTS ANTICIPATED
III. METHODS AND TIMETABLES
IV. MEANS AND EVALUATION
V. RESOURCES TO BE USED
VI. ASSUMPTION OF COST
VII. LETTERS OF SUPPORT

NUMBER SUBSEQUENT PAGES WITH A LETTER SUFFIX, I.E., 2a, 2b., etc.

INCOMPLETE GRANT APPLICATIONS WILL NOT BE REVIEWED OR CONSIDERED.

CONTACT THE DRUG ABUSE UNIT PRIOR TO FINALIZATION OF YOUR APPLICATION TO INSURE CONTENT AND FORMAT COMPLIANCE.

I. Problem

Suite 400, an outpatient community mental health center operating in Topeka, Kansas, offering specialized services to drug abusing clients and clients with high risk for drug abuse. Currently our needs are:

1.) A full-time counselor to do intake interviews, individual, group, and family counseling.

2.) Assist program coordinator by participating in community education of interested schools, churches, and civic groups.

3.) Assist in developing an adequate and increased network of referral sources. This would mainly be accomplished by further developing contacts within agencies and/or systems we are already providing services for.

Suite 400 is presently finding its needs to be different than they were a year ago. At that time, a grant was requested and utilized for someone to provide psychological testing and to develop an evaluation measure. As this grant ends, we are asking for a continuation grant for a full-time counselor. Many of our clients by the nature of their problems, chemical abuse/addiction, are oftentimes unable to pay for their treatment. Because we are a private, non-profit agency receiving no other funds than third party payments or fees for services, we cannot adequately operate without outside support at this time.

Approximately 50% of our clients are funded by Title XIX medical cards, 10% are insurance with the collection rate being 2 to 3%, the other 40% are paying on a sliding scale which averages no more than $4.00 per hour.

The grant has been a source of a staff position for the past year. Suite 400 greatly needs to have a continuation grant for a full-time counselor as our client load has increased and because 50% of those are adolescents, more time is required from the individual counselor.

II. Results anticipated

With the provision of a full-time counselor, appropriately trained in individual, family and group counseling, Suite 400 will be able to provide treatment for 15-20 drug users and/or their families that can only pay minimal fees. It will also provide Suite 400 with another person to educate interested community groups on drug abuse and to make the services of Suite 400 known to referral sources.

III. Methods and timetables

Upon Grant approval, Suite 400 will hire a qualified counselor. Ideally, an effective starting date for a new employee would be on June 1, 1977. Within thirty days, the counselor would be providing intake interviews and carrying individual and family cases: supervision of this phase of the project is to be provided by the Coordinator of Outpatient Services and the Clinical Supervisor.

By September 1, 1977, in addition to the above, the counselor will begin a group process: supervision of this by the Medical Director. Also, the counselor by this time will have begun developing and coordinating referral sources: supervised by the Coordinator of Outpatient Services.

Within six months, the counselor will assist and participate in community education: supervised by the Coordinator of Outpatient Services.

IV. Means and evaluation

Quantitative measurements to be used:
Number of clients seen in ongoing counseling.
The existence of an ongoing group process.

Qualitative measurements to be used:
Utilization of client evaluation form will provide qualitative measure of services provided to ongoing clients.
Utilization of counselor evaluation form will provide qualitative measure of counselor's skills.

The above measures are the responsibility of the Coordinator of Outpatient Services in collaboration with the counselor and the Clinical Supervisor under the direction of the Medical Director.

V. Resources to be used

Position to be filled by an as yet to be determined person. Job qualifications are as follows:

Minimum qualifications: B.A. in Psychology, Social Work or related area; minimum one year experience in field of drug abuse, experience in counseling, community education and working with other community agencies.

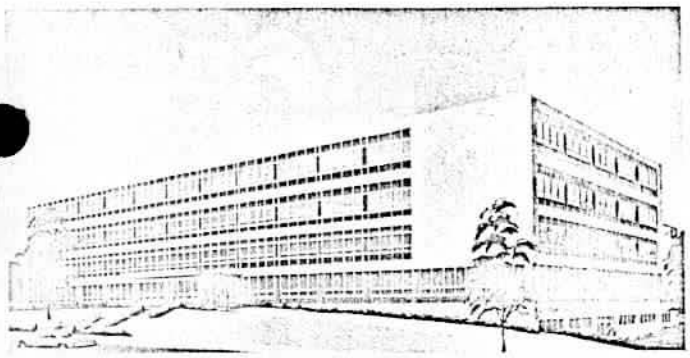
VI. Assumption of Cost

Suite 400 is a Community Mental Health Center operating on a fees for service basis. Approximately 50% of our clients are funded by Title XIX medical cards, 10% are insurance with the collection rate being 2% to 3%, the other 40% are paying on a sliding scale, which averages no more than $4.00 per hour. This staff person will be added into our cost-reimbursement accounting system according to the grant match ratio at the end of each fiscal year.

Suite 400 anticipates that within three years we can assume the full cost of this staff position by:

1. Developing programs which will meet the community's needs. This would expand referral sources and generate revenue.

2. Three years will allow Suite 400 to explore other avenues of funding for future needs.



Shawnee County

Board of Commissioners

MARY L. BOGART, Chairman

ROLAND G. HUG — LARRY D. WOODWARD

RM. 205, COURTHOUSE — TOPEKA, KANSAS 66603

March 31, 1977

Mr. Curtis E. Hartenberger
Drug and Alcohol Abuse Section
2700 West Sixth - Biddle Building
Topeka, Kansas 66606

Dear Mr. Hartenberger:

This letter written in support of Suite 400's request for a full-time Drug Counselor to do intakes, provide on-going individual and group counseling for drug abuse clients, and provide family counseling.

This person would also be available to work with other agencies, schools, etc. having questions regarding drug abuse.

Sincerely,

Mary L. Bogart

Mary L. Bogart, Chairman

MLB:jw

KANSAS
DEPARTMENT OF CORRECTIONS
Division of Probation and Parole

March 18, 1977

Ms. Nancy Belohlavek, Coordinator
Suite 400
1319 Lincoln
Topeka, Kansas

Dear Ms. Belohlavek:

The Topeka Parole Office considers Suite 400 and their program a very valuable resource to our clients. This program provides out-patient counseling to both men and women we refer for alcohol and drug addiction.

The program is very well organized, highly professional, and works closely with this office.

Sincerely,

Victor Obley

Victor Obley
Regional Supervisor
Topeka Parole Office

VO:jf

March 24, 1977

Nancy Belohlavek
Suite 400
1319 Lincoln
Topeka, Kansas

To Whom it May Concern:

Suite 400 has provided services for seventeen special education students from Capital City High School within the past 6 months. Their services have included individual and family therapy, counseling, psychiatric counsultations, and psychological evaluations.

Their promptness and effectiveness with students that have been referred is outstanding and the school staff has not hesitated to refer some of our most difficult students and families. Suite 400's flexibility in working with families that other agencies have terminated has provided a service that we feel is unique in our community. We feel the total program has become more effective with the degree of communication and consultation Suite 400 has provided for the student advisors and teaching staff at Capital City High School.

The entire Capital City Staff and I have no reservations in recommending Suite 400 to receive grant monies. They have provided outstanding services for the students and staff at Capital City Schools.

Sincerely yours,

Ben W. Gaut

Ben W. Gaut
Principal

BWG/sb

14. BUDGET DETAIL

	% Appl Cont	DAU Funds Requested	Applicants Cash Contribution	Applicants In-Kind Contribution	Anticipated Earned Income	Total Funds Required
1. PERSONNEL COMPENSATION		$8750.00	$1450.00			
Salaries - New Personnel						
Salaries - Existing Personnel				$1817.16		
Salaries - Training						
Employees' Hospital Insurance		XXXXXXXXXX	$201.37			
Social Security Contributions		XXXXXXXXXX				
Retirement Contributions		XXXXXXXXXX				
Total of this Category			$1651.37			
2. CONTRACTED CONSULTANT SERVICES				$2475.00		
3. TRAVEL AND SUBSISTENCE			$208.00			
Art Workshops			$50.00			
4. SUPPLIES AND REPRODUCTION						
Office Supplies						
Printing				$10.00		
Other						
Total of this Category						
5. COMMUNICATIONS AND POSTAGE						
Communications				$150.00		
Postage and Freight				$172.94		
Other						
Total of this Category						
6. EQUIPMENT						
Equipment - Purchase						
Rental of Equipment				$40.00		
Pamphlets, Books				$10.00		
Furniture and Fixtures						
Other						
Total of this Category						
7. FACILITY COST & IMPROVEMENTS						
Rent of Real Estate				$138.86		
Utilities				$140.00		
Insurance, Real Est. & Equip.				$70.39		
Maint. Materials & Supplies						
Renovation & Remodeling				$30.00		
Construction-Bldgs. & Struct.		XXXXXXXXXX				
Land Acquisition		XXXXXXXXXX				
Other						
Total of this Category						
8. OTHER EXPENSE						
TOTALS		$8,750.00	$1,909.37	$5,054.35		

Less Anticipated Earned Income	
Net Project Cost	
Less Applicant Contribution (Cash & In-Kind)	$7,127.93
Amount Requested From DAU	$8,750.00

15. BUDGET NARRATIVE: Define Amounts Reflected in Budget Detail by Each Category Number, Separate and Identify Total DAU Support, Applicant Cash Support, Applicant In-Kind Support, and Anticipated Earned Income for Each Item in Each Budget Category.

Budget Cat.	NARRATIVE	AMOUNT				
		DAU	Applicant Cash	Applicant In-Kind	Anticipated Earned Income	TOTAL
1. New Personnel	This would be additional salary paid to the person hired.		$1,450.00			
Existing Personnel	1 hour per week-- Executive Director 2 hours per week-- Coordinator 4 3/4 hours per week-- Clerical Staff		$1,817.16			
2.	Each counselor is required to be in one hours supervision for each modality (family, individual, group) per week. Supervision is provided by one of Suite 400's consultants-- psychiatrist, psychologist, MSW. The figure shown is for 2 hours worth of supervision per week.					
3. Travel	Counselors are reimbursed for travel. Average monthly travel has been 160 miles.		$208.00			
	Mileage and workshop fees.		$ 50.00			

conditions and guidelines listed or referred to above.

A. Glenn Leonardi, Executive Director

Name and title of official authorized to sign application and obligate applicant agency.

Glenn Leonardi — March 25, 1977

Signature of above stated authorized official — Date

B. Nancy Belohlavek, Coordinator of Outpatient Services

Name and title of Project Director, if different from authorized official in A. above.

Nancy Belohlavek — March 25, 1977

Signature of Project Director — Date

C. Glenn Leonardi, Executive Director

Name and title of Project Financial Officer

Glenn Leonardi — March 25, 1977

Signature of Project Financial Officer — Date

18. Total number of pages in application: 12

19. REVIEW: The undersigned certifies to have reviewed this application and acknowledges the substance of the proposal, and recognizes a responsiblity to consider the continuation financing requirements the program will face if successful.

A. _____

Signature of local unit of government official, Title, Date

B. _____

Signature of local community drug abuse council president (if one exists). Date

Council should either attach any comments to this application, or forward them directly to the DAU.

RESEARCH

RESEARCH ON TREATMENT MODALITIES FOR THE PHYSICALLY DISABLED

It was our original hypothesis that "Branching From Within", would encourage significant positive changes in physically disabled clients behavior and emotional outlook upon life. This was written up in detail during the first trimester and is listed in the appendix of this paper. In summary, the initial hypothesis stated that the clients would develop more self-confidence in their physical and emotional self through developing an awareness of untapped power and abilities within themselves. This consisted of a combination of individual supportive counseling along with a structured program involving the use of a daily journal, a behavior chart, and training stereo cassettes by R. Monroe. (Refer to paper by J. Ransom on Altered States of Consciousness and to the appendix.)

Because this was run out of a mental health center and is a clinical program, we were unable to follow any strict research methods.[1] The most reliable method would be a single subject study.

The controls in the different studies are as follows.[3] All clients were seen in their homes. All clients had severe physical disabilities. Two clients were studied in depth in each group. One of these had a stable disability such as Cerebral Palsy. The other had a non-stable disability as in the case of Multiple Sclerosis. One client in each group was a male and one was a female. The age ranged from late twenties to mid-sixties. The time of the study was eight months. The therapist was the same in

the studies. The "variable" in this study was the treatment modality.[4]

Significant results have been recorded in all single subjects involved in the complete program including, individual counseling, the daily journal, the self-monitoring behavior charts, and the training cassettes. Descriptive case summaries of these are written in the paper by J. Ransom on Altered States of Consciousness.

A comparative single subject study was done on two other small groups of clients. The first one included supportive counseling without the behavior charts, daily journals, or tapes. The therapist was the same.

The second comparative single subject study group was done on a group of five physically disabled young adults at a residential home for them. They were around the same therapist but did not participate in any of the therapy modalities mentioned above. The therapist served in this situation as the house manager.

The results in the single subjects study concerning the use of individual therapy, charts, logs, and tapes are in agreement with the original hypothesis. There was an increase in externality and motivation which lead to an increase in socialization and physical life activities. There was a decrease in depression and anxiety. Pain control or management has been achieved. A decrease in medications for anxiety and depression requested and an increase in better sleeping patterns have been recorded in all single subjects studied. For a more detailed list of the positive changes recorded in these subjects refer to the appendix of this paper.

The results in the single subjects study on the clients who were involved only in individual therapy are summarized as follows.

There has been no decrease in requested medication for anxiety or depression. There has been no decrease in better management of pain. The depression level of the clients has fluxuated greatly from severe to mild. The motivation of the clients to improve in their daily living activities has also fluxuated greatly with the pattern of increases followed by decreases.

There has been an attachment to the therapist by the client often displaced as a dependence upon the therapist. This is recorded by measures including calls made to the therapist for advice during office hours and after hours as well as asking for advice during the therapy sessions.

The last single subjects study mentioned concerns the residents living at the home for physically disabled. An increase in both pain and medication requested for anxiety and depression was recorded. Socialization and motivation levels remained the same. There has been an increasing dependence upon the house manager recorded. These include calls and request for attention or unnecessary assistance from the house manager. There has been an increase in the number of calls the clients made to their medical doctors. There is no change in weight or diet patterns. There are no significant changes concerning daily life activities.

In summary, these results point to the increased amounts of positive changes[5] in the clients in the complete program compared to the lack of

significant positive changes in the other two subjects studied.

We are continuing to keep data on all three methods of therapy. The first we have named as structured therapy. The second is un-structured and the third is the control involving no therapy at all. It is natural that the validity of this study, pointing to the use of the structured program for the best results, may be in question. Because it was a clinical study clients could not be randomly selected for each study yet as many controls as possible were implemented. It is also important to consider the time-limited factor since at this writing, the study has only been operational for eight months. This study will continue and a second writing after the next eight months will be used as a comparative study to further check the validity and bring to light more information concerning the most effective treatment modalities to implement when working with physically disabled clients in a mental health setting.

This method of research on clinical work has been implemented by therapists such as Erik Erikson. He developed his theories about conflicts within the ego producing symptoms and emotional distress in disagreement with Freud's concerning sexual drives, after working clinically with first American Indians then with war veterans. In 1950 he published the decade of work he had done through clinical observation.[6]

Franz Alexander studied psychosomatic disorders. He associated them with certain specific psychodynamic patterns. He evolved on the basis of his own clinical studies certain psychophysiological disorders including - peptic uler, colitis, bronchial asthma, hypertension, neurodematitis, rheumatoid arthritis, and thyrotoxicosis.[7]

Alexander felt that the essence of psychoanalytical therapy is to bring the client's consciousness of his or her emotions and motivations under his or her conscious control. He was one of the first therapists to introduce flexibility. He felt the therapist should adapt his or her technique to the needs of the client. He and his students experimented with different clinical situations such as the length of the sessions, the amount of time needed in preparation for termination and the environmental structures of the office.

In our program, "Branching From Within", we try to use this concept of flexability. Most of all we agree with Rollo May's ideas. He feels that the overall goal of therapy is to help people recognize themselves as humans by overcoming blockages which keep them from meaningful relationships. He says most essential in this process is accepting and esteeming themselves as individuals.[8]

In "Branching From Within", we consider the individual client's needs first and the research information we are able to draw from the clinical data from the case studies, secondary, though no less important in its proper perspective.

Jenny Ransom

FOOTNOTES

1. Glazer, Myron. The Research Adventure (promise and problems of field work. New York Random House. 1972.

2. Brewer and Freud in 1895 in "Studies in Hysteria" used this method. Freud developed most of his theories after studying one case of a certain nature in depth.

3. Laboritz, S. and Hagedorn, R. Introduction to Social Research. New York. McGraw-Hill Co. 1971.

4. Ibid

5. "Positive Changes" are considered by the treatment team and supported by other literature to include: activities or behaviors which move toward the further development of a "steady state" in which the whole system (internal and external) is in balance.* Anderson, R. Human Behavior in the Social Environment Chicago, Aidine Pub. Co. 1974. p. 18-19.

6. Elkind, David. Erik Erikson: Psychosocial Analyst. Nutley, N.J. Roche Pub. 1975.

7. Marmor, Judd. The Contributions of Franz Alexander to Modern Psychotherapy. Nutley, N.J. Roche Inc. 1975.

8. May, Rollo. Existential Psychotherapy. Hoffman-La Roche Inc. 1975.

* "balance changes, and even its structure changes".

APPENDIX ON RESEARCH

12 agencies March-'77

March 1977

Branching From Within

A program for individuals with physical/medical disabilities

Dear Directors:

Please send us information concerning grants you award to programs working with physically/medically disabled individuals. A description of our pilot program is enclosed. We are interested in expanding and continuing this program for persons with physical/medical disabilities but are in financial difficulties.

We are presently supported by collected client fees and Suite 400. Many disabled persons are disqualified from insurance policies and transferred to Medicare which pays only $312 per year for outpatient psychiatric treatment. If maintained on insurance, a number still do not fund outpatient treatment. Only a limited number of our clients are eligible for Title XIX (Medicade). Clients ineligible for third party payments are charged for services. These fees are established on a sliding scale. However, many individuals are able to pay very low fees. Many individuals we are presently seeing are overwhelmed by the cost of their continuing medical care such as equipment, medications, physician and hospital fees, that adding one more cost that is not a "necessity" for "survival" is something they would forgo.

Branching From Within became operational July 1, 1976. Suite 400, a private, non-profit, outpatient mental health center, was willing to provide us with the initial start up costs. This agency will continue to provide our program with office space. However, they are unable to financially support any of our other needs i.e., full salaries, new equipment, travel expenses, etc., which is a real necessity to our continuation and further development of this program. It is important to us not only to provide a needed service to clients with physical/medical disabilities, but also to continue researching and developing treatment models effective for this population, in order that we can share our knowledge with other professionals.

Topeka is an especially good location for this program because there are many institutions which serve the disabled such as a sheltered workshop, a halfway house for disabled young adults, the Capper Foundation for crippled children, Kansas Neurological Institute, as well as three local hospitals focusing in on rehabilitation, oncology and cardiac care. The city of Topeka has done much work toward accessibility and making the public aware and concerned about the needs of disabled persons.

Funding for a program like this will always be an issue. However, if we were able to secure funding to further develop and establish our program, this would allow time to explore community funding sources.

It would also provide the community with time to become familiar with services we provide as it requires much time to become a part of the medical communities.

PROJECTED ANNUAL BUDGET REQUEST

Program Director, M.A. - $16,000
Clinical Director, M.A. - $15,000
Therapist, M.A. - (Full-time) - $11,500
Psychologist PhD (½ time) - $4,500
Consultant, M.D. (1/8 time) - $4,800
(4) Students (travel expenses) - $200 year
Secretary - $6,000
Supplies - $4,000
Travel expenses/continued education - $10,000

TOTAL REQUEST $72,000

The sponsoring agency, Suite 400, will supply the rent and office space; furniture; some equipment; receptionist coverage; the sponsoring agency has supported the first year in which the "Pilot Program" has been run. (Refer to appendix: "Costs-Budget for Pilot Programs".)

RATIONALE AND HYPOTHESIS

Counseling:

It is our premise that counseling in conjunction with the use of tapes will allow a person to live as full a life as possible physically, emotionally and environmentally. Both the tapes and counseling may be used separately to bring about a change. However, only the mind and body working together can make it possible for the individual to realize their full potential.

Throughout the process the use of tapes and counseling complement each other. We see this process as :

* Encouraging a person to become involved in their own physical well being and opening an awareness to the untapped power which could aid them in this involvement.

* Working with the person on emotional and environmental issues that might otherwise prohibit them from participating in altered states of consciousness.

* Introduce the individual to altered states.

* As the individual becomes skilled at utilizing this altered state, the realization that they hold this power, increases ones self-confidence. Counseling supports this increased self-assuredness as well as encourages it to become integrated into a person's life by making noticeable behavioral changes i.e.: increased social interaction, increased independence; a more positive self-image; etc.

* Directly dealing with psychological pathology which might otherwise block physical and/or emotional benefits.

Tapes:

Tapes have shown that they:

* Aide in relaxation and sleep which helps stimulate fantasy

* Aide in the natural process of healing

* Offers pain control in some patients

* Help develop a better self-image

It has been shown through biofeedback, yoga and relaxation exercises that the mind has latent powers over the body. What we hope to show is that people have the ability to tap into this latent power. Therefore they can use this power in a constructive and helpful way to increase their personal growth and self-actualization.

METHOD

Subjects

A minimum of twelve subjects will be worked with during the first six months. Ss will be asked to sign a Medical Release of information and a consent for treatment.

Design

Evaluation: All Ss will complete the evaluation. This will be three weeks. The evaluation will consist of three parts: The Interview; Autobiography; and Psychological Testing. Each of these parts is described in detail below:

Interview

The Ss will be interviewed by both Nancy and Jenny together. Both social workers will rate their suitability feelings about the subject independently and then discuss this during the final evaluation meetings. These sessions will be taped if consent of Ss is given. A copy of the Clinical History Data Sheet is enclosed. This is the general outline of information to be gathered. Special attention will be given to the person's adjustment to their physical disability such as: coping patterns, flexibility to changes, adjustment to losses, social and work skills, sexual adjustment, dreams and fantasy experiences, and the ability to be assertive.

Procedure

Following the evaluation period of three weeks, an assessment will be made of the subject's suitability for the program. Then a decision would be made as to which program they would be best suited for at this time. The two programs are: (1) Counseling, (2) Counseling with the training tapes.

In Program No. 1, the subjects will meet with counselors once or twice a week for individual and/or group therapy.

In Program No. 2, the Ss will meet three hours a week--one hour for individual counseling and two hours in a group. The group will explore the area of altering states of consciousness, relaxation training, and group dynamics.

Tapes

The Tapes used will be:

The Natural Process of Healing (3 hours).
Exploring the New World (2 hours).
- Relaxation by W.7 Arnesen (30 minutes)

Monroe Star System (10 hours).

This is a minimum time required. The group will meet for two-hour sessions to listen to and discuss the tapes and feelings of the group. Before any tapes are listen to, the group will meet and get to know one another. After all the tapes have been completed, the group will continue to meet for the remainder of the contracted time (6 to 8 months total time). The group will focus upon their reactions to the tapes, group itself, and other special topics, such as assertiveness training, will be offered. All subjects will be asked to keep an ongoing daily log or journal of their significant experiences, including emotions, dreams, etc. A behavioral monitoring chart will also be kept in which the Ss will monitor their daily tasks (decided upon individually) such as motor skills, diet, social activites, etc.

Self-Assessment/Autobiography

The self-assessment will include the evaluation of the Ss and significant other (s) current impressions of their present emotional outlook. A copy of this is included in the appendix. The autobiography will be a taped or written account of the Ss assessment of their life focusing upon: Family history, philosophy and beliefs (religion), significant experiences during childhood, adolescences, and adult life, A copy of the autobiography data sheet is included in the Appendix.

Psychological Testing

The testing will be administered pre, during, and post treatment. They will be scored and evaluated by a psychologist who has had special training in the field of physical disabilities. The specific test will be geared to discover material in the areas listed below:

Coping

Body Image

Self-destructive Behavior

Reality Testing

Emotional Reaction

Excesses or Distortions

Language and Communications Skills

Self-esteem

(Copies of the test are included in the Appendix)

Trimester III Grant

RATIONALE AND HYPOTHESIS

The program, "Branching From Within", can offer a multitude of new growth experiences and changes for individuals with physical/medical disabilities or crippling medical problems. Through this program, the client develops more control over their physical, mental, and emotional self.

HYPOTHESIS

The treatment program, "Branching From Within", will stimulate behavioral and psychological changes in physically disabled people. These changes will be monitored by the use of client and therapist evaluations, daily charts, logs, psychological testing, and significant other evaluations.

The following outcomes predicted: increases in self actualization, social inteaction, verbalization, creativity, and self-motivation; decreases in anxiety, insomonia, pain, and depression; development of a more positive self-image, increasing independence by a means of self-realization and self-exploration.

PILOT STUDY

SUBJECTS

The experimental group consisted of six adults all with physical disabilities. The control group consisted of six adults with physical disabilities. The disabilities in the experimental group were: cancer, arthritis, paraplegia (spinal cord injury), multiple sclerosis, athero scierosis, parkinsons disease, cerebral palsy, and internal derangement of the knee. The disabilities (medical problems) in the control group were: cerebal palsy, grandmal seizures, spinal bifita, ulcers, migraines. In the experimental group, there were three men, three women. In the control group, there were three men, and three women.

DESIGN

All subjects in the experimental and control groups were administered psychological tests dealing with: Death Concern, Body Image, Personal Orientation Self Rating Scales, significient other rating scales, profile of adaption to life scale, and profile of moods. All subjects were observed by the therapists in the experimental group in a (structured) therapy setting in the control group in a home for the disabled setting (unstructured). The subjects in the experimental group were put officially into the structured program, "Branching From Within". They were required to (1) complete a three week evaluation period in which they wrote an autobiography, (2) complete the psychological tests, (3) met with the therapists to discuss their goals and interest in the program, (4) they developed measures for self-monitoring daily charts, and (5) kept a daily dated journal of their life events and experiences. All of the control subjects were studied for one year. Some additional clients were worked with on a less structured basis due to their individual needs. The experimental subjects were studied for one year to seven months.

RESULTS

Individual case summary reports are available on all subjects with appropriate confidentiality of all subjects accounted for. In a group summary, the experimental group showed significant changes. (Refer to appendix changes made while in the program). The control group showed no significant changes.

SIGNIFICANCE

There is a lack of therapeutic programs for people with physical disabilities and disabling medical problems. The program "Branching From Within", offers disabled individuals a relatively short term therapy program which enhances significant growth and developmental changes in them. The pilot study has shown in a controlled and systematic fashion the effectiveness of this program in the subjects psychologically and behaviorally.

The potential implications of this basic research are many fold. This program can be used in a variety of settings such as institutions for the physically disabled, outpatient mental health settings, rehabilitation programs, and halfway houses for the disabled. This program offers comprehensive coverage because it is open to people of all ages with any kind of physical or medical disability who are in need of some assistance with their adjustment to their disability. The client can be worked with in several different settings including the office, their home, a hospital, or an institution.

While various treatment centers for the disabled are currently in operation, "Branching From Within", is a new idea concerning the therapeutic focus upon the individual client as a whole person as it helps the client develop on many different levels at once, this being a holistic approach. In addition to helping individuals with physical disabilities, the community also benefits from the workshops and continuing education classes that are given by the staff of, "Branching From Within".

POSITIVE EFFECTS OF "BRANCHING FROM WITHIN"

1. Relaxation Training

   a. sleep improves

      (1) duration
      (2) soundness

   b. decrease in nervousness

      (1) decrease in symptoms caused by "nerves"

         a. dry mouth, nausa, feeling faint, skin problems (itching, pimples)

   c. decrease in muscle spasms/shakiness

2. Decrease in (M.D.) Doctor Dependencies

   a. clients focus more on their improvements instead of minor medical and psychomatic symptoms

   b. clients develop more self-confidence

   c. clients develop a more reaslistic view of their disability or medical problem

   d. client develop other supportive relationships (friends, family, therapist)

   e. reduction of negative symptoms

3. Decrease in Intake of Medications

   a. relaxation training substitutes - barbituates

   b. increase in sleeping patterns - (less need) barbituates

   c. less nervousness and sounder sleep (less need) barbituates

   d. development of pain management (for need) barbituates

4. Increase in Self-Motivation

   a. clients become more goal directed

   b. clients become more independent

   c. clients become more social

Positive Effects of "Branching From Within"

4. d. Clients develops creativity

(1) arts and crafts
(2) writing and poetry and reading
(3) other activities

e. clients develops interests in self-responsibility

(1) work
(2) school
(3) independent (more) living
(4) volunteer activities

Monroe Institute of Applied Sciences

P.O. Box 57
Afton, Virginia 22920

MONROE AUDITORY GUIDANCE SYSTEMS

SURGICAL PROGRAM

The Monroe Auditory Guidance Systems (MAGS) offer the individual, group, and organization a modern method of attaining desired personal attitudes and emotions beyond the capability of the conscious mind alone. This is achieved through a series of training exercises embodying a synthesis of established and newly-developed principles related to the symbiosis of consciousness and the physiological mechanisms of the human being.

Basic among such principles employed is a technique of inducing relaxation and sleep through a pattern of audio pulses which evoke a frequency following response (FFR) in the human brain. This method was the subject of a generic patent granted to the parent Corporation in May, 1975. Through this method of non-verbal audio signals, pulsed at sequential and mixed alpha, theta, and delta brain-wave frequencies, natural sleep is induced without drug medication. In addition, selected patterns are used to produce deep relaxation and intermediate stages of sleep, which are effective in reducing tension and stress-produced symptoms.

Another technique utilized is the effect of "binaural beats" created in the brain through separate audio signals to each ear--the enhanced crossing of the Corpus Callosum, as it were. This permits integration, expansion or devolution of consciousness into either or both brain hemispheres as may be required by a particular MAGS program.

Other methods included are vocal derivations of guided imagery and suggestology (Losanov) to assist the participant in the formulation of mental "tools" under his conscious control. So that such methods and techniques can be applied properly and with requisite controls, all exercises are presented on audio cassette tape. The participant uses stereo headphones to insure audio isolation from ear to ear, and from external noise distractions.

This, then, is the fundamental thrust of any MAGS Program: to aid the individual in the creation, development, and conscious, willful application of such mental tools as may be needed for his own physical, emotional, and intellectual well-being.

THE SURGICAL PROGRAM

The MAGS Surgical Program has as its purpose a means to provide solutions to the immediate mental, physical, and emotional needs of the surgical patient. Such needs are: reduction of anxieties, reinforcement of confidence factors, adjustment to alien environmnet (hospital), resistance to post-operative shock, control of pain, and acceleration of body healing processes. By communication directly into the prime survival mechanisms of the mind, it is possible to strengthen and redirect these drives into fulfillment of the immediate needs as indicated. The MAGS techniques make this possibility of "talking to the unconscious mind" a reality.

One way to approach the concept of the Program: think of it as a new friend who will be with the patient almost continuously throughout his stay among strangers in a strange place called a hospital. The confidence and reassurance, even during the surgical process itself. When help is needed, the friend shows the patient ways to gather his own

recuperation, depression, or the simple business of a good night's sleep. The friend not only shares the experience, but is experience, and passes this constructive value on to the patient.

In the administering of the Surgical Program, it is essential that all related members of the hospital staff be alerted to both planned and potential deviation from standard hospital procedures. Further, they must be made aware of probable atypical responses in the patient, to act positively when these occur.

The Program, however, is aimed specifically to fit into the usual routines for the surgical patient. Any variation will be in degree rather than actual replacement of method or technique. Therefore, no changes should be contemplated except for the application of the taped exercises where required by the Program.

In the application of the actual Program, these are the basic mechanical requirements:

(1) A preliminary discussion with patient and physician concerning the Program and what to expect.
(2) A comfortable loudness or volume level of the sound as approved by the patient. (Once such adjustment is made, it need not be repeated as all taped exercises have the same output level)
(3) The patient's room must be partially darkened and reasonably quiet.
(4) Except for an emergency, the patient must not be interrupted during any exercise (about 45 minutes).
(5) The proper taped exercise must be used as indicated. No substitutions should be made.
(6) Each exercise must always be fully rewound so that it is started at the beginning.

In terms of patient response, these factors may be observed:

(A) Pre-Operative

- Increased relaxation
- Ability to sleep naturally
- Reduced pain

(B) Intra-Operative

- Lowered blood pressure
- Less anaesthetics required
- Deep, regular breathing
- Lowered heart rate

(C) Post-Operative

- Early recovery from anaesthesia
- Control of Pain
- Accelerated healing
- Sleep without medication

The following is the schedule of a typical MAGS Surgical Program:

Interview with Patient, Physician, MAGS Technician

(Discussion of purpose of program, how and when it is applied, methods involved. Agreement and authorization by Patient.)

[1] Exercise #6701 - AT WORKUP
(Introduction and patient experience with actual techniques involved. First stage relaxation, reinforcement of confidence and sense of self-value, first structuring of pain control.)

[2] Exercise #6702 - IN HOSPITAL
(Pre-sleep, night before surgery: reinforcement of self-relaxation, confidence, self-value, pain control, into normal sleep.)

[3] Exercise #6703 - IN HOSPITAL
(Immediately after pre-op sedation: short relaxation method, structure, balance, confidence, strength, pain control, into normal sleep.)

[4] Exercise #6704 - IN O.R.
(45 Minutes: may be repeated as long as necessary to cover actual OP time; direct reaffirmation of confidence, strength, balance, reinforcement of survival mechanisms, erasure of pain memory, calm and serene.)

[5] Exercise #6705 - IN RECOVERY
(To be used to return patient to consciousness; confidence, strength, pain memory erasure, pain control at conscious levels, reinforce healing mechanism, calm and serene attitude, balancing system, return to wakefulness.)

[6] Exercise #6706 - IN HOSPITAL
(Recuperation: to be used two or more times daily, including pre-sleep at night, whenever patient requests it or feels tired; short relaxation, direct affirmation of confidence, strength, pain control, healing mode, system balance, into normal sleep.)

MONROE AUDITORY GUIDANCE SYSTEM

SAMPLE CASE RESULTS

#2101 R.A. - 1959, Winston Salem, North Carolina

Admitted to Baptist Hospital with diagnosed coronary occlusion. Original system used; patient released from hospital at 1/2 expected recuperative period based upon sed rate, other test. Patient's mental attitude major factor, no anxiety or depression. Results significant enough that Hospital requested copy of tape for their own research.

#2 - R.M. - 1971, Dallas, Texas

Admitted Baylor Hospital for bi-lateral caroted surgery. System was employed on patient for second operation five days after first surgery including O.R. itself. Twenty percent less anaesthesia was needed, minimum pain medication, system replaced sedation and drugs for sleep. Pronounced high confidence.

'3 - S.H. - 1975, Waynesboro, Virginia

Patient admitted to Waynesboro Hospital with scheduled back urgery, and under sedation for pain. History of 10 previous operations ue to chemicals used to avoid rejection of transplanted kidney. Thus, istory of patient under surgery was well-known, and with predicted esponses. Patient had three sessions under MAGS systems prior to rgery, including immediately after pre-op sedation. Results: 30% less aesthesia required, early recovery to full consciousness, only one moral injection for pain during entire recuperative period in hospital, eping medication required, early discharge from hospital.

FIRST AFFIRMATION

Say in your mind, say to yourself: I am more than my physical body. Because I am more than physical matter, I can perceive that which is greater than the Physical world. Therefore, in these exercises, I deeply desire To Expand, To Experience; To Know, To Understand; To Control, To Use such greater energies and energy systems as may be beneficial and constructive to me and to those who follow me. Also during these exercises, I deeply desire the help and cooperation, the assistance, the understanding of those individuals whose wisdom, development and experience is equal or greater than my own. I ask their guidance and protection from any influence or any source that might provide me with less than my stated desires. I now protect myself as may be needed from such influence and reject any source that may restrain me from my stated desires.

SECOND AFFIRMATION

I open this channel of communication only to those whose knowledge, wisdom, development and experience is equal or greater than my own. I restrict such contact and communication to constructive purpose, and reject all other. I open such channel only when I so consciously desire; at all other times, it will remain closed.

[7] Exercise #6707 - AT HOME
(Optional: For use by patient in home convalescence, to move into self-actuated control of stress-tension, sleep, pain, and body system balance.)

The MAGS Surgical Program takes the position that all healing is performed by the physical body itself, upon instruction from the mind. The efforts of the physician center principally on reinforcement of mechanical and bio-chemical processes of such body efforts. The MAGS programs work to enhance amplitude and content of signals from mind to body so as to reinforce directly the matrix of healing at the source. Therefore, both physician and guidance system complement and inter-act in a joint effort without encroachment. The results may well be a balanced method of treatment that can open new approaches to the problems of human dysfunction unilaterally unavailable to either discipline.

The Development of a Style of Counseling Through the Integrated Therapeutic Approach for Clients With Physical or Medical Disabilities

Nancy Belohlavek

In developing a theoretical frame of reference I have reviewed literature on personality development, current psychotherapies, and existing programs for persons with physical and/or medical disabilities. There is a definite lack of literature dealing with counseling techniques or personality development of persons with physical disabilities. (For literature reviewed see bibliographies for trimesters 1, 2, 3 to be found in Section VIII). Most literature available on disabilities deals primarily with the medical aspects of treatment rather than the psychological adjustment process. The other aspect dealt with in the available literature views medical problems as psychosomatic illnesses. There are two books which spoke directly about psychological aspects of physical disabilities. They are Physical Disabilities - A Psychological Approach, B. Wright (1960) and The Psychological Aspects of Physical Illness and Disability, F. Shontz (1975). Neither book addressed viable techniques to be used in counseling with disabled individuals.

Shontz and Wright both deal with disabilities or handicaps as medical problems which affect the psychological make up of an individual. Shontz goes into detail about the body image and how this affects a person's self concept. Shontz also speaks directly to the medical issues of disabilities. When personally talking to the authors, Jenny and I discussed techniques or literature that would be appropriate for developing a frame of reference in counseling with the handicapped and were offered few suggestions. Shontz was especially outspoken about not placing the handicapped individual in

a role of "mentally ill". He was quite hesitant to discuss counseling with the disabled as he felt he knew of no programs outside of rehabilitation facilities which provided a comprehensive approach.

Wright speaks directly to the rehabilitation concerns and medical aspects of the handicapped. She speaks to the attitudinal barriers that affect the handicapped individual.

Because of this lack of literature and program models, we have explored existing theories and therapeutic approaches in order to establish our own frame of reference. To do this we have drawn from the existing theories of personality and therapeutic approaches that seem to be applicable to working with the psychological adjustment of the handicapped. This is by no means complete as our approach is new and open to change as we gain more empirical evidence and practical wisdom and read other existing theories.

The following is a brief overview of the theoretical approaches we have drawn from and deal with the counseling techniques we have developed. The other treatment modalities theoretical basis we have used are addressed in Section VI.

In describing the psychosocial stages of development, Erikson suggests that an individual's social propensities are bipolar. While all of these social senses are present from the start of life, there is a period in the life cycle during which a particular pair, because of a complex of developmental and sociocultural factors, comes into special prominence. The experience that occurs during this period has more than usual impact upon

strengthening or weakening the bipolar propensities. Consequently, each phase in the human life cycle passes a kind of crisis for a particular pair of social senses inasmuch as experiences during this period have an inordinate effect upon the propensities in question. This is not to say that the outcomes of these "crisis" are permanent and unchangeable, but only to emphasize that the outcomes tend to be self-reinforcing and hence are more difficult to change after the critical period is over.

The onset of a physical disability in any stage of development will greatly enhance the crisis of that period and will interfere with further development. Erikson states that a physical, mental or emotional handicap will reinforce a childs' sense of inferiority. In the elementary years when a sense of industry is being developed some young people may deny their sense of inferiority and claim that this failure is due to "laziness" which nicely captures their weakened sense of industry.

In developing an ego identity a young person integrates what she/he has learned about herself/himself from social roles and relationships. The problem with constructing a sense of ego identity is complicated by the multiple changes undergone by the adolescents. Adjustment to the body is important. When the adolescent already feels inferior it becomes difficult to feel other than a worthless whole. The adolescent then experiences an intensified sense of role confusion characterized by uncertainity as to what she or he can be. Because of the burden of inferiority and role confusion, friendship and true intimacy become difficult

to establish. The consequence is a sense of isolation which often leads to feeling alienated from society. The extreme of isolation is the recluse, but there are many people with a strong sense of isolation who live and work among, but not really with other people.[1]

In working with disabled clients, the therapists strategy must be to strengthen the sense of ego identity to the point where a relationship becomes possible. As Carl R. Rogers states in this basic theory of client-centered therapy if certain conditions are present in the attitudes of the therapist, namely genuiness, empathic understanding, and positive regard, then positive personality change will occur in the client. If these definable conditions are present, then the client will gradually allow her/his self-actualizing capacity to overcome the restrictions she/he has internalized. The client-centered therapy focus is on the present experiencing of the client, believing that the reestablishment of awareness of and trust in that experience will provide the resources for growthful change. The therapist facilitates the clients discoveries of the meaning into her/his own current experiencing.

Client-centered theory does not find it necessary to assimilate complex diagnostic definitions, intricate webs of theory, protocals of techniques to be applied to situations. The theory states that a person who can be real, caring, and understanding, can count on being an effective facilitator of growth in a helping relationship.[2]

My digression from the client-centered therapy is at the point of not providing advice, direction or clearly pointing out reality to the disabled client by the therapist. In William Glasser's Reality Therapy, the therapist seeks to force the client to face reality and reshape their behavior in order that the client may fulfill their needs. When people do not fulfill their needs they come to regard themselves as failures. Becoming involved with a disabled individual who perceives themself as a loser or failure, and is suspicious, hostile or lonely, is no easy task. Learning to become involved in reality therapy is both the most important and difficult assignment for the therapist. The reality therapists state the following 14 steps are the way to achieve this involvement:

(1) Warm, friendly, personal, optimistic and honest.

(2) The therapist reveals at least a little of themself.

(3) Uses the first person "I" and "me" as much as possible.

(4) Concentrates on the here and now.

(5) Concentrates on the behavior rather than feelings.

(6) Questions what versus why.

(7) Insists that the client evaluate her/his behavior.

(8) Formulates a treatment plan with the client.

(9) Negotiates a contract and commitment with the client.

(10) Doesn't waste time listening to excuses.

(11) Moves client to groups as soon as possible.

(12) Uses praise, encouragement, rewards, and touch.

(13) Does not press too hard.

(14) NEVER, NEVER GIVES UP.[3]

Reality Therapy's concept of mental health is for a person to have a positive self-esteem, acceptance of oneself, respect, confidence, trust, openness, integrity and honesty. For the disabled client, all of these areas may be affected. We feel that when there is an absence of one or all of the concepts of good mental health it does not constitute "mental illness". Thomas Szasz (Autonomous Psychotherapy), Hobart Mower (Integrity Therapy) and William Glasser (Reality Therapy), all agree that commonly uses psychiatric classifications of "Mental Illness" are of little value in the consideration of psychotherapeutic procedures.[4]

This concept of not placing a great emphasis on diagnosis is important for the disabled client as so often adjustment and self-actualization are viewed as an illness rather than a normal process. It is our premise as with the Radical Feminist Therapy to take and work with the whole person, to bring about some realistic change. The Radical Feminist Therapy promotes a great deal of interaction and experiential sharing between client and therapist. Because of the sharing the radical feminist believe it will increase the clients' self-esteem enabling the client to become active. Radical Feminist therapy strongly supports an integrated approach to therapy working on insight, feelings, and political action.

The strongest bond between the Radical Feminist Therapy and our integrated approach for disabled clients is rejecting traditional patriarchal therapy that for so long has discriminated against their needs and developed instead a flexible and integrated approach.

(1) Erikson, Erik H., Identity Youth and Crisis. New York: W.W. Norton and Company, Inc., 1968.

(2) Corsini, Raymond, Current Psychotherapies. Itasca, Illinois: F.E. Peacock Publishers, Inc., 1976.

(3) Bassin, Brates and Rachin, Editors, Reality Therapy Reader, New York: Harper and Row, 1976.

(4) Greenspan, Marrian, Speech given to 1976 International Conference of Feminists and Therapist. Boulder, Colorado.

One of our goals both within the program, "Branching From Within", and in continuing our educational and professional development has been to focus on developing our own style of therapy to help handicapped persons develop a positive self-image, independence, and self-control. After working with both physically and medically disabled persons for several years, we have begun to identify some common problems. In this paper we will: (1) summarize subjective and objective information that we have gathered over the past years through observation and direct work with handicapped individuals and (2) describe our therapeutic approach to working with handicapped persons.

We define a handicap as a condition resulting from paralysis, neuromuscular or neurological disease, arthritis, stroke, severe pulmonary or cardiac disease, mental retardation, emotional disturbance, blindness, deafness, amputation, temporary injury or the natural process of aging.[1] It is our feeling that handicapped persons represent a minority and they are often discriminated against, similar to racial and ethnic groups. These prejudicial attitudes affect the psychological adjustment of handicapped persons.[2]

In spite of the growing numbers of disabled people (estimates are 25 million) our society is not designed for handicapped individuals but rather for able-bodied persons, who can walk and move about freely. Architectural barriers are at different times, in different ways, the cause of many of the problems associated with handicapping conditions and frequently do not accommodate such things as wheelchairs, crutches, canes, and walkers which then become handicaps instead of aids to mobility. Persons confined to wheelchairs may not be able

to go through doorways or contend with stairways or have access to restrooms, drinking fountains, and phones. Those who are handicapped by blindness are affected when the communication is exclusively of a visual nature. Deaf individuals have difficulty in communicating when messages are only auditory. Transportation is a problem for all handicapped people. Often mass transit is not accessible and cab companies resist helping a disabled person because they fear a law suit if the person falls or they don't want to take the time. Again the deaf and blind face similar problems.

Unemployment and underemployment among the handicapped are serious problems. According to the 1970 census, there are more than 35 million physically and mentally handicapped persons in the United States. Of that number, approximately 11.7 million non-institutionalized persons between the ages of 16 and 64 were listed as having been disabled for more than six months. At that time over 6 million disabled persons were not in the labor force. Many handicapped persons have been prevented from joining the labor force as a direct result of environmental and attitudinal barriers imposed by our society.[4] Such daily problems faced by handicapped persons have frequently caused humiliation, frustration, and reduced opportunities for productivity, participation, and independence.

Living opportunities for many handicapped persons are dismal. Persons who require any assistance with daily living activities are forced to live with family members, with a spouse, with an attendant (which very few can afford) or reside in an institution or a residential facility. Because of lack of independent living facilities, many of the young disabled live in nursing

homes. Although a handicapped person must be dependent on others one of her/his greatest fears is not being able to remain functional within the community. An alternative living arrangement such as Independent Living Centers (ILC) in Berkeley, California, can provide her/him with more independence yet it will be many years before this type of adequate living arrangement will be common-place.

A person with a handicap severe enough to need some assistance in daily living activities is faced with meeting the basic survival needs of having a place to live where she/he can be provided with physical care, yet helped to be functional within the community. Struggling with these realities seriously affects a handicapped individual's psychological adjustment.

Well-adjusted persons must be able to balance external societal expectations with internal desires and drives as Joan Bardach tells us.[5] For handicapped individuals, the difficulties of living up to the demands of the culture in terms of behavior, appearance, independent functioning, are of greater magnitude than those experienced by non-handicapped persons. Such a heavy balance of societal expectations weigh heavily on many handicapped persons who may come to view the world as a hostile and antagonistic place. In such an environment of distrust, such persons dare not express their feelings, including the frustrations and anger related to the psychological dependence with physical dependency. These handicapped individuals often isolate themselves from others and try to hide, mask or deny their feelings as well as their physical or medical disability. This is done in hopes of being accepted by society.

One area where denial is a common practice is in seeking employment. Many prospective employers will not hire someone who has diabetes, epilepsy, cancer (even if non-active), cardiac disease, or other concealable disabilities. Employers may refuse to hire individuals with an obvious disability, hiding behind flimsy rationalizations such as inaccessibility to facilities or inability to understand, as in the case of cerebal palsy or other disabilities affecting speech. For both the non-visible and visible disabilities, an increased insurance rate is another common excuse for denying employment. Because of the continuous lack of positive reinforcement from society, the disabled may go to one of two extremes: becoming dependent or child-like, as a way of manipulating the environment to fulfill their needs, or becoming counter dependent by setting unrealistic goals and expectations for themselves and often rejecting assistance from other persons.

According to Joan Bardach, "All of these areas of adjustment, the acceptance of limitations, the development of alternative capabilities, the avoidance of psychological dependence, the battle against feelings of inferiority, the quest for social integration, can result in anxeties for the handicapped person which drain valuable psychic and physical energy."[6] It is imperative that professionals working with handicapped individuals understand their problems in order to be effective. Therapists or counselors must understand the developmental stages of the disabled and have an understanding of different adjustment processes for different disabilities, i.e. congential, progressive, time limited, or stable. It is, of course, understood that in order to make counseling with the disabled more effective, much research is still needed in the area of how the adjustment process differs according to onset, duration, nature and severity of the handicap.

The therapist or counselor who understands the evaluation of the different stages that a handicapped person goes through, recognizes that the initial denial can be important for the individuals' emotional stability as it serves to lessen the feeling of being overwhelmed by her or his tragedy. We, therefore, need to acquire a history of onset of the disability working from that point to the present. Our goal is to help each client grow to a point where she or he is able to adjust to their handicap.

Following the denial stage, the person may struggle to adjust to her or his handicap which is accompanied frequently by an increase in depression resulting from the recognition of limitations. A handicapped person may need to go through a period of mourning for the specific function lost. This mourning may continue until the individual can withstand the totality of the loss. As Bardach states, "The presence of such depression, by itself, is not necessarily a sign of emotional difficulty. It may only mean that the individual is becoming strong enough to cope with the realities of her/his condition".[7]

Two factors are important in the initial adjustment process. The first is the severity of the loss. The second is the personal value which the individual places on all those experiences affected by the loss. Self-confidence and self-concept are closely related to body image which is often affected by physical and/or medical disabilities. This is true for individuals with either acquired or congenital disabilities.

In developing "Branching From Within", a program for individuals with physical or medical problems which cause an alteration in life style, we take into account the external and internal problems delineated above. Our therapeutic approach is one of integrating the whole person, physically, emotionally, and intellectually. Our method from the beginning utilizes a "joining approach" of the therapist and client working as a team during the therapeutic process. Too often the handicapped individual is not involved at all in her or his own treatment, or is left fully responsible for it, with no help. It is our hope that our work with the handicapped will enhance their dignity and self-esteem which, if reinforced, can be maintained after the treatment process ends and will enable the handicapped individual to make a self satisfying adjustment.

During the first contact the therapist reviews the medical and social history of the client. The first step is asking clients to complete an autobiography. Most clients are provided with an outline and asked either to write or record their autobiography. However, with some of our elderly clients, we may spend a number of therapy sessions having them talk about their lives. It is explained to the client that the autobiography is confidential and will be returned after the therapist has gone over it. The autobiography provides the therapist with a detailed account of how the individual views her or his life. Whenever possible, we include psychological testing, using tests developed for disabled persons as well as standardized tests. "Norms" for the handicapped are different from "norms" for subjects who are not disabled. We are presently developing our own rating scales

which are applicable to our clientele.

The second step is a comprehensive evaluation of the problems to be confronted in treatment. We meet with clients once a week for one hour evaluative and assessment interviews. In the first sessions, we try to develop a rapport with the client, establishing possible goals, acquiring background information, and finally discussing openly whether the client wants to continue in the process.

In supervision the therapist reviews all the gathered materials with the co-therapist and medical director in order to establish treatment modalities and direction. The therapist then shares with the client the initial recommendations direct from this review. It is at this point that the client and therapist make an agreement to work together. The therapist and client negotiate a contract that specifies as distinctly as possible the following factors, as Seabury delineates: "purpose of the interaction; target problems; various goals or objectives; administrative procedures or constraints; roles of participants; techniques used; and time limitations".[8]

The third step in "Branching From Within" is the therapy itself. Following the guidelines agreed upon through the process described above, the client and therapist work on establishing treatment goals such as becoming less depressed and withdrawn, interacting with others, exploring alternative recreation or job possibilities, pain control, or developing mental means of regulation of bodily controls. Initially, most clients are seen twice a week either in the office or at their home. Home visits are made for clients who are too disabled to come to the office, have no

transportation, or are too withdrawn to get out into the community. Clients are encouraged during the treatment process to come to the office if this is at all feasible.

Initially, the therapist listens and establishes empathy. This is not a quality of pity, but rather action, a shared hope for change. Wright[9] pointed out that persons who suffer do not want others to suffer with them for nothing is gained. A sufferer wants relief, which cannot be acquired when the therapist becomes equally helpless out of sympathy or pity. If the client is depressed or withdrawn, she/he uses techniques to evoke activity of any kind. At times we find an activity helpful in drawing out a client. During home visits the therapist may discuss objects within the home in order to facilitate conversation. Because of the active role the therapist plays in the treatment process, it is important to establish early the boundaries and guidelines of the relationship. The client needs to feel the therapist has strength, as this demonstrates to the client the therapist's ability to handle anger and to help through conflicts, especially the ones around dependence. Having strength does not mean that the therapist should not frankly admit not understanding a client's particular emotion or reaction. It is best for the therapist to be honest and encourage the client to explain fully any puzzling responses.

"Supportive Confrontation" is our term for a therapeutic approach which we have found to be constructive. The therapist confronts the client with reality, encourages expression of feelings, supports the clients strength and positive actions and offers suggestions and alternatives.

The therapist "confronts" the client with reality by pointing out behavior which may be affecting interaction with others (poor dress, body odor, or personality traits); physical, architectual and attitudinal limitation; or options the client is choosing (complaining they have not been socializing, however, they turned down an invitation). The therapist "supports" the client not only in expressing and owning their feelings but also by assisting the client in finding alternatives and generating ideas. The "supportive confrontation" is an integrated approach whereby the therapist facilitates the client to be an active participant.

As the treatment program progresses many clients become depressed, and they may regress, even when therapy has been successful. Regression and depression are often seen by the handicapped as signs of failure. They experience a sense of helplessness and hopelessness--"nothing I do will ever make it any better." Clients often fear that the therapist will leave them at this point and so the therapist must provide encouragement and strength. The length of time it will take for the depressive and/or regressive symptoms to improve will vary greatly with each individual and depends on many factors, including outside support, the extent of loss, how much change in life style is required, whether the disease is progressive, and whether there is chronic pain.

If supportive confrontation succeeds, the client becomes aware of her/his self defeating characteristics and is able to open up and share her or his concerns and fears. It is at this time that the client accepts the therapist's assistance. Once a client has asked for help, the client

often becomes more highly motivated and is willing to work toward realistic goals. However, it is common in this stage for the client to try to manipulate the therapist. Some times manipulation is seen in calling the therapist at home to talk about feelings of loneliness or to ask for advice. The client is trying to make the therapist responsible for everything. It is up to the therapist to shift responsibility back to the client. This can be done by engaging the client in finding a solution to specific problems. Two indicators of success are seen when the client begins to give advice, and starts showing more of an interest in the therapist as well as other people. This is the first stage in the process of building a positive self-image. Encouragement is still extremely important. This growth process may take a long time in some cases and is never without its ups and downs.

As a technique, supportive confrontation is an intense experience for the therapist, demanding both strength and patience. The therapist must continually re-evaluate the goals established for self and client. The handicapped client brings overwhelming problems to therapy, many of which will not change. The therapist must be aware of this and must encourage each client to become excited about small gains. For the handicapped individual, any achievement reflects major efforts and, therefore, can contribute positively to improved self-image and growth.

The last stage of this program is termination which, for many of our clients, is an extremely slow process. We encourage participation in activities, as we gradually reduce the number of visits and substitute phone calls for face-to-face contact. Although follow-up will be

continued for a year, all clients are informed that the therapist is available at a later date if necessary. This is reassuring for clients who know that life occurences change and may require new adjustments. For individuals with progressive diseases, this is especially important because of the nature of their condition.

Let us turn now to the treatment modalities that we have found valuable. The first of these is a self-monitoring behavioral chart developed by client and therapist. This chart has 12 to 15 different items which measures significant attitudes, feelings, and behaviors. Clients monitor the amount of physical exercise they get, their emotions, diet, socialization, or significant occurences which they may want to either increase or decrease. The client fills these out daily and turns them in to the therapist at each visit. In this way both client and therapist monitor change and review the changes noticed. For depressed clients, the chart helps to focus them on a limited number of questions, thereby reducing their feeling of being overwhelmed by the magnitude of their problems.

Another therapeutic tool we have found helpful is a daily journal. This is a summary written or recorded by the client, or in some cases, it may be as simplistic as an appointment calendar. The daily journal may include special events, feelings, dreams, or routines. This is given to the therapist to be reviewed and is returned to the client. We have found clients to be more open with the journal than in interviews alone. The journal opens the communication between therapist and clients faster than therapy sessions alone because the therapist can use it to raise issues for discussion. After using it and becoming more comfortable with it, the client becomes more open with the therapist.

Other modalities we have used are guided imagery, relaxation training exercises, and simplified biofeedback techniques to assist the client in body control and gaining self regulation abilities.

The purposes of using Imagery in a psychotherapy session are many fold. If carefully done, the therapist can develop an aliance with the client more quickly and in greater depth than in most verbal forms of therapy. The reason for this is that the defenses that the clients use on the conscious verbal level are bypassed as the clients begin to expose to themselves and to the therapist unconscious thoughts and feelings in the form of images. In doing this, the client must feel that the therapist is both a guide, a support, and a partner in sharing their discomfort of the evoking and sometimes frightening images.[10]

During Guided Imagery the therapist's style of dealing with the clients' images vary from conservatively interperting them on an analytic basis to being as non-interpretive as possible but encouraging the client to examine their images and discuss them. As with psycho-analysis, the client who is involved in imagery therapy usually begins to remember dreams more vividly. This is very helpful since the clients dreams often parallel with their weekly imagery sessions.

Relaxation training has been used extensively as part of the recent rising popularity of "Biofeedback".[11] Significant results have been achieved with a variety of clients: a decrease in nervousness and spasticity; a decrease in numbness or coldness due to poor circulation; a decrease in stiffness or soreness due to tension, and a lessing of insomnia, as W.A. Love has shown.[12] Besides the actual positive effects of relaxation training, the clients also begin to under-

stand that they are able to control and change their physical and emotional selfs. We have observed our clients developing a more positive body images and self-concepts.

Simplified biofeedback techniques teach clients to develop their own body control, self-regulation powers and self-exploration. We are presently using the Monroe Star System training tapes, which incorporate the use of both guided imagery and relaxation training with non-verbal audio signals causing changes in brain wave frequencies, as in biofeedback.

We have found the above treatment modalities to be effective because they add another dimenson to the therapy. Besides focusing on mastering the external world a client can be helped on the internal world. This change of focus trains the clients to use their inner strengths and abilities on both the physiological and mental levels.[13]

In our work with handicapped persons, we have stressed helping the individual to integrate intellectual, physical, and emotional aspects of self. We try to do this by combining a number of the treatment modalities with counseling clients about where to obtain services, alternative recreational outlets and job opportunities. We also try to be open to new ways of accomlishing this goal. We have found that only when the mind and body are working together do our clients realize their full potentials. This encourages handicapped persons to view themselves as a whole, often for the first time. Many handicapped persons are preoccupied with their physical selves and, therefore, teaching them positive methods of strengthing, controlling, and being involved with that part of themselves encourages a

positive self-image. In "Branching From Within" we have observed handicapped persons who developed the strengths to exercise self-control and a degree of independence through the integrated therapeutic treatment program.

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THE THERAPEUTIC USE OF RELAXATION, GUIDED IMAGERY, AND ALTERED STATES OF CONSCIOUSNESS TRAINING WITH CLIENTS WITH PHYSICAL DISABILITIES

Jenny Ransom

INTRODUCTION

New forms of therapy all directed in varying ways toward releasing the self from the domination of the ego through both emotional and physical excerises and training have become very popular in the 1970's, as seen in the cover story in Newsweek.[1] These include: transactional analysis, primal scream, bioenergetics, rolfing, yoga, guided imagery, gestalt therapy, psychosynthesis, E.S.T., biofeedback, acupuncture, meditation, and a variety of kinds of encounter groups. Many of these "therapies" have been studied for many years by renown people including William James, C. Jung, G. Lozanov, and S. Freud. The Indian Swamis' have been involved with many of these practices for years. This new outbreak of humanistic psychology has branched off into different segments such as transpersonal psychology which focuses upon the belief that psychic energy can be controlled and transferred between people.[2]

The common factor between these new forms of therapy and the traditional forms of counseling and psychoanalysis is that they are structured for people who are not limited by physical or medical disabilities. They are geared to the abled-bodied person. The need for a specialized therapeutic approach towards people with physical and medical disabilities has been studied in depth in the paper "The Integrated Therapeutic Approach for Clients with Physical or Medical Disabilities", by N. Belohlavek and myself, J. Ransom.[3] In this paper it is pointed out that people with disabilities are unable to participate in

1. Newsweek, September 6, 1976.
2. Newsweek, September 6, 1976.
3. Belohlavek, N. and Ransom, J. "Integrated Therapeutic Approach", Unpublished 4-'77.

many of the therapies mentioned above due to their physical limitations which restrict both their movements and sensory abilities, as in the case of deafness, blindness, and paralysis.

There is a definite lack of literature or programs independent of rehabilitation institutionalized settings. "Branching From Within", an outpatient program for people with physical or medical disabilities developed by myself and N. Belohlavek (1976), is an innovative program developed solely for disabled clients. Ms. Belohlavek and I made a review of both grants awarded to programs for the disabled along with a review of the literature which pointed to the lack of programs for the disabled. B. Wright, author of Physical Disability (1960) and F. Shontz, author of The Psychological Aspects of Physical Illness and Disability (1975), both discussed this lack of writings and programs.[4] This was further confirmed after getting substancial responses in support of this program from professionals from different parts of the country.[5]

Because this is a new therapy program, there is little to compare it against as a whole, but it can be broken down into small segments using clinical data in comparison to more traditional forms of therapy. An example of this is the problem of chronic pain.

The managing of pain has become an increasingly popular topic of research and study today. Psychotropic drugs like tricyclic anti-depressants and

4. Wright, B. and F. Shontz. Personal Communications on literature available on the disabled. 1976.
5. Personal Communications from professionals in California, Missouri, and Kansas.

phenothiazines have been studied in the management of chronic pain. In the study by Merskey and Hester (1972), they found that the drugs helped reduce anxiety along with the alalgesic effects.[6] The problems, they pointed out, include often severe side-effects including promoting both physical and medical problems.

In the program, "Branching From Within", we try to help the disabled clients increase their own powers of pain control or management with the use of Guided Imagery and Altered States of Consciousness training.

Imagery often called, "Suggestology" was pioneered by G. Lozanov in Bulgaria in the 1960's. He developed a method of teaching the student or client while in an altered state of consciousness using a variety of methods including, yoga, hypnosis, deep relaxation, and sound.[7] Suggestology has been used to rapidly teach students languages and in clinical settings. Lozanov has reported a 15% average increase in alpha-theta brain wave production during the "suggestology" sessions. These methods have been compiled in the cassette form by Robert Monroe which our program has been using. In addition to the cassettes, we have been using guided imagery and relaxation training. These three therapy modatilities are described in detail as case summary reports in the latter part of this paper.

There has been significant reduction in pain reported by clients who have been involved in this therapy program. The kind of pain has varied from severe inflamation of the joints from arthritis to intolerable pain from

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6. Merskey, H. and Hester. "The Treatment of Chronic Pain with Psychotropic Drugs." Postgraduate Medical Journal, Oct. 1972.
7. "Suggestology - Based Methods Explored," Brain Mind Bulletin. Vol. 1 No. II. 4-19-1976.

cancer. In both these two cases mentioned, a significant reduction in pain accompanied a marked decrease in the amount of medication requested by the clients. In the case concerning the arthritis, the medication was gradually eliminated completely.

In addition to teaching the clients "pain control" these imagery, sound, and relaxation methods, help the clients develop their own mental abilities and controls, thus encouraging self-motivation and increasing independence. Through a step by step imagery program, the clients learn to draw strength from their inner selves and rely upon their own abilities to help control their internal emotional and physical parts. This then expands from their internal to their external abilities, as they continue to increase their feelings of self-worth and self-actualization. (Refer to case study summaries).

It is usually not until the disabled client can feel more confident with their own self-worth and identity that they can begin to use a more traditional group therapy setting. Yalom explains in depth what he considers then primary curative factors that can occur in a group therapy setting but in order for clients to be able to use a group process, they must be readily prepared for the pressures from the group despite its often overall supportive nature.[8] As the case summary of the man with M.S. indicates, he became ready for a group process after a year of individual work using the training cassettes and individual supportive counseling.

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8. Yalom, Irving. The Theory and Practice of Group Psychotherapy. 1970

Dealing with social stress is faciliated by the training in altered states, relaxation, and imagery by strengthening the client's body image and self-confidence. These therapy modalities help clients focus upon their physical and emotional bodies. Lipowski speaks to the importance of this saying, "Body experience helps determine the quality of life and reflects sensitively physiological functioning and psychosocial stress. It is influenced by emotional stimuli and in turn modifies emotional states."[9] For disabled clients the limitations of their physical state can be compensated for by their development of imagery and altered states training abilities.

The therapeutic uses of Relaxation training, Guided Imagery, and Altered States of Consciousness Training is discussed in more detail in the following pages.

GUIDED IMAGERY

The power of the unconscious and subconscious mind to affect the conscious mind has been studied increasingly since Brewer and Freud's studies in hysteria in 1895.[10] Rossi explains the importance of dreams as a means of self-reflection.[11] Ann Faraday, in her book, The Dream Game (1976) states that anyone can learn the language of her or his dreams simply by looking at them as pictures and tuning into the feelings the dream evokes. Carlos Castaneda describes his teacher having him learn to contain his consciousness during his dreams by first practicing looking at his hands during his dreams.

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9. Lipowski, "The Importance of Body Experience." Page 13, Am. Psychiatric Ass. 5-12-76.
10. Norris, Pat. "Working with Prisoners, a Study of Guided Imagery," Unpublished. 1976.
11. Rossi, Ernest. "Self Reflection in Dreams". Psychotherapy Vol. 9. No. 4 Winter. 1972.

Guided Imagery and Altered States of Consciousness training teaches the "student" or client to put her or his physical body to sleep through a process of deep relaxation while retaining her or his conscious awareness. This process is also carried over into the client's night dreams as she or he begin to have control over the dream experiences. The integration of the awake and dream states of consciousness in the client is very important. The client that appears to be leading a well adjusted life yet is having nightmares is not integrating her or his total self. By tapping into the unconscious in a controlled and guided manner, the client is able to more fully understand her or himself and then make desired changes in her behaviors and attitudes as well as learning more self-regulating techniques of control over her or his physical body.

The purposes of using Imagery in a psychotherapy session are many fold. If carefully done, the therapist can develop an alliance with the client more quickly and in greater depth than in most verbal forms of therapy. The reason for this is that the defenses that the client uses on the conscious verbal level are bypassed as the client begins to expose her or himself and to the therapist unconscious thoughts and feelings in the form of images. In doing this, the client must feel that the therapist is both a guide and a support during the imagery sessions.[12] Many therapists begin a clients imaging a comfortable field. The therapist asks the client to tune into this field and describe it in detail. In addition to describing the scene the client is asked to express her or his feelings about the imagery experiences.

12. Rossi, Ernest. "Psychosynthesis and the New Biology of Dreams and Psychotherapy". Am. Journal of Psychotherapy. Vo. XXVII. No. 1. 1973.

Then next the therapist directs the client to a path and it is here that the journey begins. Initially the therapist leads the client through a very structured journey by placing objects on the path for the client to deal with. These symbols are often a cup, a soard, or a vase. After the journey the therapist leads the client back to the imagery field she or he began in.

During the session the client is in a comfortable usually reclining position with eyeshades on. The client and therapist talk softly during the session. After the session is over, the client removes the eyeshades and discusses the session with the therapist. As the client progresses the therapist gives less verbal cues and so more of the responsibility of imaging is left up to the client.

When the therapist feels the client is able to direct his own sessions without any verbal cues, the therapist substitutes music specially picked to evoke certain affects from the client. There is no verbal communication during the music session. After the music is over the client talks about the imagery experience with the therapist. These sessions are usually 45 minutes in length with ½ hour discussion time. The number of sessions is a very individualized issue which the therapist and client decide upon.

In Imagery the therapist's style of dealing with the client's images vary from conservatively interpreting them on an analytic basis to being as non-interpretive as possible by encouraging the client to examine her or his images and discuss them. As with psycho-analysis, the client who is involved in therapy usually begins to remember dreams more vividly.[13] This is very

13. Levner, Hanscral. "Guided Affective Imagery". Am. Journal of Psychotherapy. Vol. XXIII, No. 1, Jan. 1969.

helpful since their dreams often parallel with the weekly imagery sessions. A case study will illustrate the process.

CASE STUDY SUMMARY OF IMAGERY SESSIONS

This client is a white, non-amblatory, male who is twenty-eight years old, born with Cerebral Palsy. He lives alone in an apartment. He was a self-referral. He came to the program saying he had an interest in learning about imagery because he liked to write poetry and felt this would help him. He was not working and had not applied for the welfare money he was eligible for. He was over-weight and sat in a very slouched posture in his wheelchair. He was depressed and lonely, unmotivated to develop a better diet or exercise program by saying to us he only wanted to work on imagery. His depression had caused him seriously to contemplate suicide on several occasions though he had never directly attempted it. He dressed sloppily and appeared somewhat in need of a bath.

This client's history shows clearly the development of his passive-aggressive personality. He was born into a farmer's family. Because he had Cerebral Palsy, he was sent to an institution for physically disabled children. He remained in institutions through high school. Because he was motivated and bright, he was able to work during high school at a post office. He entered college and began drinking heavily and socialized mostly with non-disabled people. He developed a relationship with a woman whom he wanted to marry. She introduced him to her parents. They rejected him and the relationship fell

apart. He was hurt and fell into a very deep depression. He managed to finish college, graduating with an M.A. degree in Rehabilitation Counseling. He got a job helping administer a program. He had a falling-out with the boss and quit, again feeling very rejected. He moved to Topeka in search of a new job and a new atmosphere. He began a job as an operator for an answering service which he quit after a few weeks. He began a volunteer job at a government agency, which lasted only a few weeks. It was then he first sought treatment. After a three-week evaluation period, he began individual weekly imagery sessions with me. We decided to try it for eight weeks.

The severity of his depression, as well as his unresolved anger for his family's, his girlfriend's family's, and society's rejections, began to show up immediately in the imagery sessions. In the first session, I started him in the traditional fashion, imagining a pleasant field. He experienced all sorts of beasts running at him including, bears, snakes, and wild-cats. He was able, with careful structured guidance, to walk past them unharmed. He continued to have frightening images although he was able to escape damage with structured guidance. Because of his writing and education experience, he had very verbally clear and explicit images. He imaged himself dancing in a stone house with a beautiful woman. He was quickly dealing with several issues including his sexual frustrations, his loneliness, his anger at being disabled, and his feelings of fear of the non-disabled world. In his second imagery session, he began dealing with death. He experienced seeing all of his friends being dead in a mortuary setting and saw me dead there. In the

following session, he personally experienced death. He imaged his death as lying in a small boat, floating down a dark river. Suddenly, he realized that he was dead and his spirit floated up into the sky. He experienced a sense of nothingness. He then was reborn and experienced Jesus Christ's singing coming from a stone mountainside. Then it began to rain and the images washed away. He experienced the feeling of the rain which turned to a strom. He found shelter from the storm as his session ended.

After our initial contract of 8 sessions, he had experienced and worked on many key issues in his life. He began verbally to deal with these after each imagery session. In his last imagery session, he worked through his unresolved anger at his father. In the image, he met his father by going across a river to his parents home. They greeted him with open arms and smiles. He felt the warmth of their love and acceptance of him as a person. After the session, he expressed his joy and relief of making peace with his father. A few weeks later his father died suddenly. It was as if this client had made his peace with his father just in time. He then left town to take a long visit with his mother. He felt he was now strong enough to help support her through her mourning.

This case is an example of how quickly guided imagery can help a client work on long-held significant life experiences and resolve some of them. The power of the client's unconscious mind seemed to know the urgency with which he had to work in his sessions. Each week when he came for his session, I could feel his discomfort in lying down for his imagery session and once into the session, the twitching and marked changes in his facial

coloring showed the intensity of the images with which he was dealing. Yet he kept pushing himself until he finally flowed through much of his pain and experienced the warmth and acceptance he had not felt for twenty-eight years.

RELAXATION TRAINING THROUGH MODIFIED YOGA

Relaxation training has been used extensively as a result of the recent widespread interest in "Biofeedback".[14] Significant results have occurred in a variety of clients. Many physical effects such as a decrease in nervousness and spasticity, numbness or coldness due to poor circulation, stiffness or soreness due to tension, and decrease in insomnia problems have been helped or in some instances cured.[15] Besides the actual positive effects of relaxation training, clients also begin to understand that they are able to control their physical and emotional self. They are able to develop a better body image and self-concept. I have developed some modified Yoga exercises for people with physical disabilities (see appendix). These can be done while sitting in a wheel-chair.

RELAXATION TRAINING THROUGH MODIFIED YOGA EXERCISES

The importance of daily physical exercise for all people has been studied in many different ways, ranging from muscle development to body chemistry.[16] It has been shown that the body is healthier and stronger through the use of exercise combined with a diet sufficient in vitamins, minerals, and protiens.[17]

14. The Journal of Bio-Feedback Vol. 3, No. 2, Summer/Fall 1976.
15. Love, W.A. "EMG Feedback and Relaxation Training as Ancilary..." Pg. 3, Journal of Biofeedback. Vol. 3 No. 2 1976.
16. Satchidananda, Yogiraj. Intergral YogaHatha. N.Y. Holt, Rinehart and Winston. 1970
17. Ichazo, Oscar. Arica-Psycho-Calisthenics. N.Y., N.Y., Simon and Schuster 1976.

People who spend their life sitting, whether it be in a wheel-chair or an office desk, need to do regular physical exercise in order to keep up their muscle tone, circulation of their bodies fluids in their blood, and to insure their muscle flexibility and strength. Yoga exercises have been shown to do these things.[18] Only twenty-minutes of Yoga exercises a day can make a very positive change in a person's body, thus affecting her mental state. Often meditation is included in Yoga exercises, either as a spearate program done before or after the exercise or while doing the exercise. An example of this is the meditating on a mantra while doing the Yoga exercises. These exercises are listed below. Other exercises such as swimming, using the whirlpool, jogging, just to mention a few, are also excellent for the mind and body. No matter what kind of physical disability a person has, exercises are possible and beneficial.

There is a blind man who goes to the YWCA who jogs slowly around the indoor track using his cane to keep him on the course.

ALTERED STATES TRAINING

The most recent technique that has become a popular therapy is Altered State of Consciousness training. There are many forms of this such as meditation, induced trance, and audio stimulation. We use audio training cassettes. The training tapes used are patented by Robert Monroe. He adds to the imagery and relaxation methods special audio pulses which serve as a white noise that helps the brain to produce the alpha, theta, and deta brain-wave frequencies found in normal sleep.[19] The effectiveness of using this audio system for

18. Smith, D. "A Healthy Body Moves Free and Easy", Ch. 2, page 7. The East/West Exercise Book. N.Y., N.Y. McGraw-Hill Book Co. 1976.
19. Monore, Robert. "The Monroe Auditory Guidance Systems Surgical program." Monroe Institute of Applied Sciences, Afton, Virginia. 1976.

people with physical and medical disabilities is still in a research phase, although because of the positive results and lack of harmful side-effects, we feel very privileged to have the use of this program. Similar to the relaxation training, this technique teaches the client to develop body control and self-regulation powers as well as self-exploration. Altered States Training incorporates the use of both guided imagery and relaxation training with the added, often mystic, intrigue of the client's own personal concepts of what it is to be in an Altered State of Consciousness.

I have discovered repeatedly that clients using Altered States of Consciousness training begin to become very attached to the tapes to the point of regularly practicing them as often as three times a day. This is similar to doing T.M. Meditation daily. We encourage the client to develop more positive patterns of behavior in their daily life activities. Practicing the tapes are a part of a routine or daily structure they build in a positive way. They also develop a special feeling of security surrounding their therapist's guidance in the training program which is slowly decreased as the client becomes stronger. Significant results have been charted in all of the clients with whom I have used the audio Altered States of Consciousness training in a clinical setting. Some of these are reported as the case study summaries in this paper.

CASE SUMMARIES ON THE MONREO STAR SYSTEM CASSETTE TAPE PROGRAM OF ALTERED STATES OF CONSCIOUSNESS TRAINING

The following is a report on three clients who have completed the Monroe training tapes star system. The first client is a 29 year old man with a college education and experience in business and accounting. When he was

approximately 26 years old, he was diagnosed as having Multiple Sclerosis. Within two years, he was severly disabled: confined to a wheelchair with severe shaking, suffering from symptons of exhaustion, and diagnosed as legally blind because of damage to his optic nerve. I began working with this young man in October of 1975, at which time he was very depressed. He was tense and seemed to be under a great deal of stress. He had very little self-confidence and no plans or goals for the future. He was interested in getting into some sort of meditation program. He had been through several kinds of treatment, such as accupuncture and a variety of physical therapy programs that are often done with people who have MS. None of these seemed to help him at all. He was living with his parents in Topeka, Kansas, where he passed the time watching television, unable to motivate himself to do anything else. He had withdrawn from relationships with his friends and he was avoiding making new friends. He was somewhat apathetic about his diet and exercise program but, at our initial meeting, expressed a desire to develop these two areas more. He was taking different medications that his neurologist prescribed to control his shaking. None of his medications were successful in doing that; they usually just put him to sleep. He called his doctor frequently because he very much wanted and expected to find a cure for his Multiple Sclerosis and was becoming increasingly upset and depressed over his prognosis.

We began meeting weekly, doing psychotherapy, as well as EMG Biofeedback training on his forearms in an effort to help him gain control over his shakiness. The EMG Biofeedback for forearm muscle control also served to pre-

pare him for the Monroe tapes by demonstrating to him through his accomplishments in the Biofeedback program, that he could use his mind to control his body more than he had realized. He was successful in accomplishing some control in both tensing and relaxing his muscles through the biofeedback training. He did have some problems with the machine breaking frequently, because he shook so much that he often broke the electrodes. This bothered him and he felt very guilty about it. In the psychotherapy, we tried to focus on his feelings of guilt (that he had caused his MS in some way) being lazy, his feelings of not seeing any future for himself in life, and his general lack of motivation to engage in any activities alone or with others. He was embarrassed to go out in public because he was in a wheelchair and because he shook so much; this was also why he had cut off his friends and had not made new friends. He felt that being a disabled person was a very negative and ugly sort of thing. At the same time, however, he had trouble admitting to himself how disabled he was, and would get very angry if someone would try to help him or tried to encourage him to compensate for his disability. Everytime MS was talked about or he talked about his condition, he would break into tears. He would also cry very inappropriately whenever he would talk about anything particularly emotional.

In the spring of 1976, I began using the Monroe Training Tapes with this young man. I had begun having this client use a self-monitoring behavior chart in which he daily recorded several different behaviors and affects that were improtant in his life, such as his diet, number of hours sleeping, exercise

program, and different moods. He also kept a daily journal in which he summarized how his day had been. He used a cassette recorder to do this and would turn in this tape to me at our weekly session. Initially, he had many problems with the training tapes. He would fall asleep on many occasions and miss the whole session and would have to repeat many of the tapes two or three times. I attribute this partly to his own defenses and partly due to the fact that his MS condition made him very tired. He also had trouble hearing some of the tapes and he often complained about the audio level, saying that he could not understand the voice. So some tapes we did over and over again because he was unable to understand what was on them. (I had asked him to get his hearing checked because I thought that this might have been part of his condition rather than a function of the tape.) He owned a stereo casette system and was able to begin working on the training tapes at home in the late spring of 1976. He began first to work on the living body map, and introduction to focus 10. He listened to the tapes, usually twice a day. He recorded how many times he would listen to the tapes on his behavior chart. In the psychotherapy sessions, we tried to focus on his feelings.

After six months of treatment, this client showed marked improvement in verbal expression and appropriate emotional expression. No longer did he burst into tears whenever his Multiple Sclerosis condition was mentioned; he was able to talk calmly about his condition. He overcame his fear of being seen in public and began to go out to stores and to restaurants with his relatives and friends. He enjoyed these excursions and in the therapy session talked about what a good time he had had during the week. He became much more

concerned with his diet and his exercise program. He continued to do this weekly and marked it on his behavior chart. His assertiveness increased to the point that he began calling up store managers and requesting that they make their building accessible for people in wheelchairs. In the past summer, he began selling vitamins at home. He became interested in activities such as leather crafts. He began to make new friends, some of whom would go swimming with him regularly at the YMCA. In the psychotherapy session, he was able to work on unresolved feelings from his past relationships with his parents. He especially focused on the fact that his father had favored his brother who was more athletic than he had been in high school.

During the fall of 1976, the client began accupuncture again with a doctor in Kansas City. He is still looking for a cure and has the goal of getting rid of his MS condition, though he is going about doing this in a more realistic way than before. He also has tried things such as massages using hot water and towels which made him shake more, so he tried cool massages, which seemed to help. His visits and calls to his doctor and neurologist decreased, and he decided not to take medication at all for his shaking. He had not been helped by tranquilizers, such as valium, which his neurologist had prescribed.

This man has become more open about his feelings and much more accepting of his MS condition. He shakes less and recently has been told by an eye doctor that his vision seems to be improving slightly. He attributes this to the fact that he is not shaking as much and, therefore, his eye is not moving as much. He is more relaxed in public and looks forward to going out

regularly, to movies, to restaurants, and stores. He watches less TV, is able to tolerate living with his family; he handles his relationship with his father much better than he did earlier. He continues to use the living body map tape daily and he is also using introduction to focus 10. He is going to begin working on the new tape from the surgical program which he has recently compelted. He calls the tapes his "meditation" tapes and uses them to cure colds and aches and when he is upset.

Another client who has successfully completed the Monroe system and is practicing the tapes regularly is a 68 year old woman with severe medical problems. She has had cancer operations and cancer treatment such as radiation therapy. She was afraid that the cancer was spreading through her lymph system. She had pain and swelling in her knees and feet and hands from osteo-arthritis. She is 60 pounds overweight and was severely depressed at the beginning of treatment. After the evaluation period of three weeks, she began the training tape program and individual weekly therapy with me. This included listening to tapes twice a week and making the daily behavior charts in which she monitered her diet, her social outings, and the hours that she read, and the hours that she slept. She made a daily journal which she wrote down a summary of her day. She was very excited about starting the tapes because she had not been able to cure the cancer and felt that this was her only other alternative. Before she had completed two-thirds of the training tapes, she decided to buy her own tape recorder so that she could practice listening to the tapes at home on her own. I gave her copies of the living body maps

and resonate breathing exercise to practice at home. She practiced regularly and was able, through strong will, to become very involved in the system. In a short time she felt satisfied with the positive results the Monroe Star System. Her goals were first to help cure the cancer or prevent it from spreading. She also had severe insomnia. She often slept only three or four hours at night and would take long naps during the day. She had pain in her knees which made it very difficult for her to walk. She had swelling in her hands and the arthritis had also caused knobs in her hands that were sometimes very painful. She was taking valium to relax.

Within two months she noticed that the pain in her knees and feet and hands had decreased; after three months she no longer suffered from any pain in her knees. She began sleeping better at night and her sleep went up from four hours to eights or nine hours and she took very few or no naps during the day. She decided to substitude the tapes instead of the valium for relaxing. She went back to the cotor and was retested and they found no cancer spread. The doctor also x-rayed her knees and although he saw no changes physically in it, she continued to report the pain in her knees had decreased to the point where it no longer bothered her. I had given her a copy of the sleep tape to use at night and she often used this whenever she woke up; it helped her to go back to sleep. Her depression decreased as she became more cheerful and open in the psychotherapy sessions. She began to deal with her concerns about being 68 years old, her death, and the issue of her husband, who had died a slow death from cancer seven years earlier. She

continued to use the tapes, to keep a self-monitoring behavior chart and the journal daily. Her sleep during the night continues to improve and her depression seems to be lessening. She has applied for a volunteer job.

A third client who has successfully completed the Monroe Star System was a referral from Elizabeth Kubler-Ross. Because this man was close to death from cancer and because he was from another town, it was necessary to do a very intensive three weeks of training with him. He was in his late 40's and had been a paraplegic since his early twenty's because of a spinal cord injury in an Army auto accident. He had multiple medical problems in addition to being a paraplegic. He had only one leg. He had artificial rods in his back for support but one had broken and was causing him sever pain. At the time of treatment he was living in a very small mobile home, bedridden, with a woman who came daily to take care of him for a few hours. He was severely depressed and sleeping poorly. He was in great pain and under heavy narcotics to control this pain. He was taking Valium and shots of Demoral every few hours.

Due to physical and medical conditions, we asked him to move from his trailer into the V.A. Hospital while we were treating him to enhance his needed physical and emotional care. His extremely high dose of narcotic was almost lethal and needed to be cut down quickly. When we began the Monroe Training Tapes we met for an hour and half or two hours every day for two weeks in order to get through the Monroe System as quickly as possible. I wanted him to have a chance to integrate and comprehend all of the tapes. Initially, he had some problems with going to sleep and we had to devise a

system in which I would touch his hand if I felt that he was asleep because of our lack to time, we could not repeat the tapes too often.

After he had gone through half of the series, he decided to purchase his own tape recorder so that he could listen to the tapes on his own. The first tape I gave him was a sleep tape. He used this to relax and was able to go to sleep using this tape. Initially, he focused on the living body map because despite the fact that he was dying, he still had hopes that he could get better. He also used focus #10. He completed the "Monroe Star System 500" series and he also completed the "Surgical Program". The tapes that he focused on were the sleep tapes, the living body tape, the focus 10 tapes, and the "Surgical Program" tape No. 24. As death became imminent, he spent more time working with focus 10 and focus 12. He was able to decrease his medication and he was able to stop taking the injections and go on a liquid Brontom mix. His pain had diminished although he was taking less narcotic. His sleeping had improved and he decided with the encouragement of the therapist to be moved back home to die in the company of his wife and children. His depression seemed to be decreasing; he began talking positively about seeing his wife and children again and said that he really did want to die at home. He died October 9 and his wife reported that he used the tapes till his death. After his death his wife wrote us. She felt that the tapes had been helpful to him because he continued to use them regularly until his death.

In summary, these three clients who have used the Monroe Training Tapes all have been able to learn how to relax better and sleep longer and more soundly.

There was a marked decrease in depression level. Pain control was achieved with two of the clients. In the psychotherapy session, the patients became more adopt in discussing feelings and more honest about what they were feeling. Initially, many of the clients with whom I have used the Monroe tapes have fallen asleep while listening. I feel that this is, for the most part, their own defense, a fear of "letting go" and becoming involved with the training tapes. They have also complained about the volume of the tapes when I rerecord tapes to make copies for the clients to use. I usually tried to record them louder because many of the clients who use the tapes buy tape recorders with preamps in them which are relatively small. Therefore, it is necessary to have the tapes recorded at a very loud volume. The tapes sometimes are recorded so that it is difficult for the patient to hear or understand what is said. Some of this is deliberate; the tapes are supposed to be that way.

The voice sounds on tapes vary considerably. On some of the tapes, such as the surgical program, the voice sounds very fast as if it were recorded at a slightly faster speed than normal. On some of the tapes the voice sounds very slow as if it were recorded at a speed that is slightly slower than normal. Often the clients pay a lot of attention to the details of the production of the tapes and sometimes becomes somewhat frightened or distressed when they notice severe changes of the voice or of parts of the tape. I feel that these are minor considerations and that the tapes system as a whole is a very good program. I found that there seems to be what I call a "positive addiction" to the tapes with these clients. They use them as a

security and support. Using the Star System seems to change their mental state and self-concept. They seem to develop more self-confidence and become more goal directed. The clients with whom I have worked so far have been somewhat resistant to developing their ability to explore other states of consciousness such as focus #12. They have preferred to work on very concrete things such as a physical matter reality level. These clients, despite their defenses, have more of premonitions, ESP experiences, visions, and communication with non-physical beings. The first client mentioned, the 29 year old with Multiple Sclerosis, has increased his ESP experiences and premonitions. He has reported some communication with other beings. He is somewhat afraid of these experiences and does not try to pursue them. He has tried to remember his dreams for the past year, however, and has recorded them on his diary. He has increased his ability somewhat to remember his dreams.

The 68 year old woman who had the cancer operation reports an increase in her communications with other beings; during her tapes training she has seen some entities that have begun to communicate directly with her. She is surprisingly open to this, yet very cautious about it, and has decided to begin to use focus 12 to explore her communication with other beings. She is using the Surgical Program tape #24 and says that she has achieved communication telling her to keep trying. She also sees bright white light, a change from her initial experiences of just seeing blackness. She feels very positive about this and is becoming more comfortable talking about it. She expects to have some further communication and she has had an "out-of-the-body" experience while doing these tapes.

The forty-six year old man, who died of cancer, was dealing with death and dying. Because he lived out of town, we worked extensively with him only for three weeks and we were not able to talk to him much about his experience in using the tapes. He did begin to remember his dreams, which for him was unusual. During the initial evaluation, he said that he never remembered his dreams. After two weeks of working with him, he was able to begin to remember some dreams for the first time in twenty or thirty years.

In summary, I would say that with working with these tapes and these three cases, I have seen very positive and encouraging results medically and emotionally. The program affects clients in many different ways. Using the behavior charts, the journal, and the psychotherapy with the tapes, increases their effectiveness a great deal. We have continued working with new clients as well as some of these clients to develop this program further for treatment of individuals with physical disabilities and medical problems.

These are three different methods of training clients to be more introspective and self-relient upon their own powers of self-control and motivation. Each method has specialized focuses and each client should be very carefully evaluated so that the decision as to which methods to use can be made. There are many aspects to consider. The first one is what are the client's needs and goals in the treatment process. This would include a careful evaluation of their daily living activities. The second one is how well do they image and this includes their memory of their dreams. And lastly, is how much, if any, experience have they had in this either reading or actual

practice of any of these methods. With a highly disturbed client Altered States Training is not appropriate and for some guided imagery may not be also, though if the guide has good expertise in the therapeutic use of guided imagery, even a very disturbed client can benefit greatly from imagery. There seems to be a personality structure or dynamic involved in the choice of technique. Highly skeptical clients do better beginning with simple relaxation training. This would also apply for very nervous clients. Clients who are very creative, often do better beginning with imagery while clients in need of a great deal of structure do well with the Altered States training tapes.

These are my own impressions and are not yet "facts". I hope as I continue to work with more clients, I will begin to have more substantial data on this. It's all a matter of ability and readiness on the part of the client, and the ability of the therapist to evaluate this initially, and then to act as a competant guide.

EXERCISE FOR INDIVIDUAIS WITH PHYSICAL DISABILITIES

I. BREATHING

A. Sit up straight as you can
B. Exhale slowly; inhale slowly - 5 times
C. Cover right nostril - exhale - inhale - 5 times
D. Cover left nostril - exhale - inhale - 5 times
E. Rapid exhale and inhale - 5 times

II. NECK EXERCISES

A. Turn neck right-forward-left - 5 times
B. Bend neck right - up - left - 5 times
C. Neck rolls counter clockwise - 5 times
D. Neck rolls clockwise - 5 times
E. Neck forward and back - 5 times

III. ARM EXERCISES

A. Arms up over head and bend backwards - 5 counts (hold)
B. Reaching up right/left - 5 times
C. Arms out and circle - 5 times
D. Arms forward - left right/left - 5 times
E. Arms forward - flex hands back and forward - 5 times

IV. LEG EXERCISES

A. Lift legs up together high as you can (hold-5)
B. Leg spread - 5 times
C. Flex feet - 5 times

These exercises are all to be done slowly and without straining, you will build up your strength and flexibility if you practice these regularly. Rest for a few minutes after each set of exercises. Omit any exercises that are not appropriate but substitute when you can an alternative part of your body for one you are able to use.

CONTINUING EDUCATION AND TRAINING WORKSHOPS

Jenny Ransom and Nancy Belohlavek

WHAT: THE INTEGRATED THERAPEUTIC APPROACH

(A workshop on the treatment of clients with physical and medical disabilities)

WHEN: March 5 Saturday from 9:00 to 5:00 p.m.

WHERE: 1319 Lincoln - Topeka, Kansas

WHO: Branching From Within, is a new program being offered by Suite 400. The program is designed for services to the physically and medically disabled.

Suite 400 is an outpatient mental health center offering services to meet the needs of targeted population groups in the Topeka area. Suite 400 is currently offering services to alcohol and drug abusers and their families, reintegration services to adolescents returning to the community from state facilities, and people with physical disabilities.

Participation Requirements: Each participant is asked to bring a blanket to rest on during the audio session and eye shades. The workshop fee is $15. Bibliographies on physical disabilities and altered states of consciousness and program description will be distributed. Please wear comfortable clothing. A second workshop on advance Altered States of Consciousness with audio training will be presented if enough participants are interested at a later date. Due to audio equipment, each workshop is limited to 12 participants. *

CREDIT: This workshop has been approved by the S.W. for Licensing for 5 3/4 hours credit for full attendance.

AGENDA:

9:00 - 9:30	Coffee and name tags
9:30 - 10:30	Developing a Program for Physically and Medically Disabled
10:30 - 11:45	The Integrated Therapeutic Approach
11:45 - 1:00	Lunch (bring a sack lunch)
1:00 - 2:00	Guided Imagery
2:00 - 2:15	Small Group Discussion
2:15 - 2:30	Break
2:30 - 3:15	Training in Altered States of Consciousness
3:15 - 3:45	Small groups
3:45 - 4:45	Questions and Bibliography

PRESENTED BY: Jenny Ransom, LBSW, M.A. candidate, has worked with physically disabled persons for the past 5 years. Ms. Ransom is Co-director of Branching From Within. She is currently the House Manager for HUHR, a home for physically disabled young adults and a Research ASsistant at the V.A. Hospital. She has worked with Dr. Stuart Twemlow for 12 months on the pilot project which resulted in the development of Branching From Within.

Nancy Belohlavek, LBSW, COTA. M.A. candidate, has her degree in Social work and Community Mental Health. Ms. Belohlavek is Co-ordinator of Suite 400 and Co-director of Branching From Within. She has worked extensively with handicapped individuals in Pennsylvania and Wisconsin and served as consultant to the Franklin County Health Department for two years.

* (Another workshop will be scheduled if necessary)

WORKSHOP

I. Introduction

A. This workshop was presented by Nancy Belohlavek and Jenny Ransom on March 5, 1977, to a small group of professionals including; Nurses, Social Workers, Occupational Therapists, and a Director of a Halfway House for physically disabled young adults.

B. The workshop began at 9:30 a.m. Nancy led the first hour by explaining the program: "Branching From Within". She asked the group to share their personal and work experiences concerning physical disabilities. She pointed out the lack of knowledge available to professionals working with the disabled clients in an intergrated therapeutic fashion.

II. The second hour dealt with the psychological aspects of physical disabilities.

A. In this Nancy focused upon: (1) When the disability occurred. (2) The self concept and body image of the disabled person. (3) The psychosocial development. (4) The disabled person's ability to deal with a hostile society. (5) She then facilitated the group to discuss these issues.

B. Nancy began talking about the "Plight" of the disabled in a society set up for abled-bodied people. She talked about (1) Imposed suffering such as low-level vocational jobs (all attitudinal and physical barriers). (2) A lack of physically disabled people to serve as positive role models for the disabled. (3) A lack of therapists who are able to help the disabled person not only "adjust to their

disability but also deal with the anger and frustration surrounding their disability. (4) She closed by again stressing the need for an "Intergrated Therapeutic Approach". She used a lot of this material from a paper she wrote with Jenny Ransom (listed in this Thesis) entitled, "The Intergrated Therapeutic Approach."

III. The third hour was presented by Jenny Ransom on Guided Imagery. (Refer to paper on Guided Imagery in Thesis). She defined Guided Imagery and its therapeutic uses. She gave a demonstration of imagery to the group. This was done by playing short segments of music imagery tapes and asking the group what images they had after each one. She then discussed some clinical experiences and compared these to the groups experiences.

IV. "Guided Imagery Audio Training" - In this session Jenny played a tape on deep relaxation training. A group discussion followed.

V. "Music Imagery Training" - In this session she had the group listen to a music piece by Debuesy titled "Tone Paintings".

VI. In the final half hour, Jenny and Nancy summarized the workshop and passed out the bibliographies on both Physical Disabilities and Altered States of Consciousness.

WORKSHOP: ALTERED STATES IN THE HEALING PROCESS

I. Introduction

A. This workshop was presented to Lindenwood 4 students and other participants on April 17, 1977, by Nancy Belohlavek and Jenny Ransom.

II. The first hour Jenny introduced the first tape session with a brief explanation of how the minds powers can be developed to help heal the body. After the tape Nancy and Jenny led a short discussion of the tape. The first tape used is titled: "Introduction to Focus #10."

III. The second hour session the group listened to the tape titled, "The Living Body Map." After the tape, Jenny and Nancy led a group discussion on the tape.

IV. Summary. Jenny and Nancy summarized the groups experiences and answered questions the group had.

Bibliography from Trimester 1, 2, 3 and

Sexuality and the Handicapped

Nancy Belohlavek

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NADELSON, THEODORE "Borderline Rage and the Therapists Response" Presented at the American Psychiatric Association Meeting May 1976

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SPENSLY, JAMES BLACKER, K. H. Brief Communication; "Feelings of the Psychotherapist" American Journal of Orthopsychiat 46(3) July 1976

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"Recreation: by Park, David C., Pub. W.H.C. . .7

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"Participation in Cultered Activities" by Cassiano, Virginia, Pub. W.H.C. . .9

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"Architectural Accessibility" by Nugent, Timothy J., Pub. W.H.C. . . .11

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Workshop - Attended during Trimester III

(1) "Working with the Black Client"

Dr. Parks

Topeka State Hospital

February 22, 1977

(2) "Working with Cancer Patients"

Kansas Occupational Therapy Association

Stormont Vail Hospital

March 22, 1977

(3) "Androgymy: Toward A New Theory of Sexuality:"

June Singer, Ph.D

Lindenwood 4

March 26, 1977

(4) "1977 Conference"

Kansas Citizens Committee on Alcohol Abuse and Alcoholism

Washburn University - Topeka, Kansas

April 18-20, 1977

(5) "Kubler Ross - Lecture to Kansas University Medical School"

Dying Patients and Life After Life

Kansas University Medical Center, Kansas City, Kansas

March 31, 1977

PARTIAL BIBLIOGRAPHY OF SEXUALITY AND THE HANDICAPPED

"Attitudes of Society Toward Sexual Functioning of Male Individuals With Spinal Cord Injury"

Wada, Michael A.: Brodwin, Martin G.

Psychology 1975 Nov. Vol. 12 (4) 18-22

Surveyed 104 Ss to determine knowledge and attitudes of the general public about sexual functioning in males with spinal cord injuries. Results confirmed the existence of a belief that once an individual is confined to a wheelchair his sex life is over, although the medical evidence is that this is not always true. No difference were found among the three age groups surveyed; recent social change, the sexual revolution, and increased visibility of the disabled have done little to change knowledge about the sexuality of the disabled. Men and women gave similar responses. Even those persons having increasing contact with the disabled were relatively ignorant in this area. Figures are cited to show that physicians share this ignorance.

"Sexuality in the Handicapped; Some Observations on Human Needs and Attitudes."

Nigro, Giovannia

United Cerebral Palsy, New York, NY

Rehabilitation Literature 1975 Jul Vol. 36(7) 202-205

Maintains that parents, professional helpers, the general public, and the handicapped themselves must accept the fact that disabled individuals are sexual beings. There is, therefore, an obligation for all concerned to help the handicapped to develop appropriate sexual identities, educate them to understand their own sexuality, provide them with information about being responsible human beings, and then allow them to make their own way in life.

"Psychodynamics of the Young Handicapped Person."

Blumerg, Marvin L.

Jamaica Hosp, NY

American Journal of Psychotherapy 1975 Oct. Vol. 29 (4) 466-476

Argues that the psychodynamics of personality and ego development are related to motor development. They body image concept, important for cerebral deficits. Adolescents are particularly depressed by loss of self-esteem and thwarting of future career goals. The importance of sexuality for the handicapped is discussed.

"Sex Education: A Cooperative Effort of Parent and Teacher,"

Kempton, Winifred

Planned Parenthood Assn. of Southeastern Pennsylvania. Philadelphia

Exceptional Children 1975 May Vol. 41 (8) 531-535

Examines problems in providing adequate sex education programs for the handicapped. The roles of parents as teachers and teachers as supplements to parental education efforts are discussed. Possible parental reactions to sex education programs are considered. The need for involving parents in cooperative educational efforts, suggestions for accomplishing this goal, and suggestions for teachers working with concerned parents are included. It is concluded that parents and teachers have separate but complementary roles in helping to make the execptional child's sexuality a positive part of his identity, and limitations, and goals, a great deal can be accomplished.

"Sex Education and Counseling of Special Groups: The Mentally and Physically Handicapped, Ill and Elderly"
Johnson, Warren R.
Children's Health & Developmental Clinic
Springfield, IL: Charles C. Thomas, 1975. VIII, 213 P.
Discusses the nature of special groups and their sexuality in terms of the danger of losing individuals behind group labels and of the precautions which should be observed in sex education and counseling in this area. A detailed question-and-answer section on common developmental and other sexual behaviors is also included, exmphasizing the needs and problems of members of special groups.

"Sex Education and the Handicapped: An Examination of a Sex Re-education Program in the VA: A Preliminary Report."
Eisenberg, M.G.
Veterans Administration Hosp., Cleveland, O.
Newsletter For Research in Psychology 1972 May Vol. 14 (4) 15-16
Describes a sex re-education program established to provide the cor-injured individual with a cognitive background of humanistic understanding of sexuality, his own as well as that of others. One of the major steps toward this goal involved examination and refutation of popular cultural sexual myths.

"The Influence of Sexism on the Education of Hanicapped Children."
Gillespie, Patricia H.; Fink, Albert H.
School of Education, Ctr for Innovation in Teaching the Handicapped
Exceptional Children 1974 Nov. Vol 41(3) 155-162
Views the sex label as having a pervasive influence on the education of handicapped children. Specific attention is drawn to (a) biases contained within special class curricula which reinforce traditional roles, (b) vocational training practices which program children for economic discrimination by encouraging selection of traditional occupational roles, and (c) special class placement processes which result in the selection of a greatern number of boys than girls in all significant areas of exceptionality. The implications for major activities within special education are discussed. (48 ref)

"Facial Disfigurement: Impact on Sex Role Evaluations and Its Relationship to Acceptance of Disability."
Sieka, Frank L.
New York, Buffalo
Dissertation Abstracts International 1971, Mar. Vol. 31 (9-A)

"A Case of Feminine Transexualism."
Leger, J.; Ranty, Y.; Blanchinet, J. Vallat, J.N.
U. Limoges, Hosp. Clinic, France
Annales Medico-Psychologidues 1969, 1(1), 164-172.
A comparison with the few cases of feminine transexualism in the literature, the case described here stresses the (a) S's youth (almost 18); (b) progressive appearance of a desire to change sex, despite certain success in passing as a man; (c) fairly good social integration, through handicapped by the physical demands of male occupations; (d) influence of the familial situation an alcoholic father who is rejected by his wife, and a brother with a homosexual past; and (4) psychotic elements revealed by Rorschach and MMPI. The ensemble of facts

in this case underline "The Importance of the Familial Experience in the Fixation of Everyone's Sexual Role," Thus favoring the psychogenic origin of transexualism, rather than the organic concepts of certain endocrinologists.

"Co-education and Women's Attitudes to Men in Work and Social Life."
Dale R. R.
Occupational Psychology 1968, 42(2-3), 153-160.

Little is known of the effect of the presence of boys in a mixed grammar school on the attitude of the girls toward the opposite sex either at school or later. An exploratory study was made by questionnaire administered to over 1,000 women student teachers, who were ex-pupils of either girls' or mixed schools. Aspects investigated were social relations, working relations, and status of the opposite sex. women who had attended girls' schools regarded themselves as handicapped in their social and working relationships with men.

"Role Modifications of the Disabled Male."
American Journal of Nursing 1968, 68(2), 290-293
Discusses role modifications of the physically disabled male in terms of the cripple role, the cultural sex role, the occupational role, and the social role. It is empahsized that such patients need psychosocial as well as physical rehabilitation.

"Sexuality and the Handicapped."
Diamond, Milton
Medical School
Rehabilitation Literature 1974 Feb. Vol. 35(2) 34-40
Considers sexuality from the perspectives of the Handicapped client, the professional worker, the agency, the client's family, and the individual on whom the client's attention is focused. Specific issues covered include (a) sexual performance and expectations, (b) guilt, and (c) communication. Practical ideas for dealing with the sexual problems of the handicapped are suggested (e.g., use of sexual prostheses).

"Sex and the Mentally Retarded."
Meyerowitz, Joseph H.
Baylor Coll. of Medicine, Houston, Tex.
Medical Aspects of Human Sexuality 1971 Nov. Vol. 5(11) 94-118
Presents a selective review of the literature on sexuality among persons labeled as mentally retarded (MR). Topics covered include maturation, Role behavior, contraception, marriage and parenthood, family, and sex education. It is noted that MR children take longer to mature sexually as well as in other ways. They are handicapped by limited coping, conceptual, and adaptive skills, and by isolation from normal peers. It is suggested that reports of "abnormal" sexuality result from MR's getting caught openly doing what others do, and condone, in private. Suggestions are given for sex education and other guidance appropriate for MR children. (45 Ref.)

"Sex Education for the Multiple Handicapped as it Applies to the Classroom Teachers."
Morlock, D.; Tovar, C.
Training School Bulletin 1971, Aug., Vol. 68 (2), 87-96
Considers the areas of sexuality and sex education in a comprehensive way,

including all the degrees of variations that can be seen between the two poles of the continuum, I.E., the normal, the profoundly retarded, and the multiple handicapped, and from viewpoint of cas. The authors accept the Freudian contention that sexuality is at the core of all emotional disturbances or behavioral deviations. The difference is that more emphasis is placed on confusion and bewilderment about sexuality than in the Freudian entities of castration anxiety, oedipal conflict, and similar concepts accepted by the psychoanalytical theory. It is further emphasized that the participation of classroom teachers, as 1 of the roles, has an important influence in the psychological elements of sexuality in the pupil. (44 ref.)

"Sex Education and the Handicapped: An Examination of a Sex Re-education Program in the VA: A Preliminary Report."
Eisenberg, M.G.
Veterans Administration Hosp., Cleveland, O.
Describes a sex re-education program established to provide the cord-injured individual with a cognitive background of humanistic understanding of sexuality, his own as well as that of others. One of the major steps toward this goal involved examination and refutation of popular cultural sexual myths.

"Sexuality and the Handicapped."
Diamond, Milton
Medical School
Rehabilitation Literature 1974 Feb. Vol. 35 (2) 34-40
Considers sexuality from the perspectives of the handicapped client, the professional worker, the agency, the client's family, and the individual on whom the client's attention is focused. Specific issues.

"A Neurophysiologic View of the Neurologically Handicapped Adolescent."
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APPENDIX

COSTS-PROPOSED BUDGET AND OTHER RESEARCH AND PROGRAM DEVELOPMENT REQUESTS

Start Up Cost:

Equipment

Sound System	$ 1,200.00
Estimate includes casette deck, amplifier, six headphone sets, 12 eye covers, and casette tapes All equipment useable in other programs.	

Office Equipment

Two small desk @ 150.00 ea.	300.00
Two office desk chairs @ 75.00	150.00
Portable Casette recorder for dictation	40.00
Tape head cleaner and demagnitizer	20.00
Telephone installation	75.00
Misc. desk supplies	50.00

Supplies

Psychological testing supplies	200.00
Brochure, design and printing	200.00

Remodeling

Bathroom

Purchase and Inst. of sliding door	200.00
Purchase and Inst. of support bars	150.00

Hotel

Construction of access ramp at entrance	200.00
TOTAL START UP COST	$ 2,785.00

On Going Cost: (Annual)

Staff

Two therapists @ ½time ea.	11,235.00
Supervision: Twemlow @ 34.77, Wallsmith @ 6.35,1 hr. per week	2,056.00
Clerical time: Guliford @ 3.01 per hr, 10 hrs. per wk.	1,505.00
Consultation on as needed basis	1,000.00

Office

Room Rental @ 150.00 per month	1,800.00
Telephone @ 30.00 per month	360.00
Equipment maintenance and repair	200.00
Indirect cost @ 15%	2,273.40
TOTAL ON GOING ANNUAL COST	$20,879.40
TOTAL FIRST YEAR PROGRAM COST	$23,664.40

Assumptions and Explanations (cont.)

Income

Income assumptions are based on the premise that all patients will have funding sources capable of paying the full clinical rate charged by Suite 400. On the face of it, that may appear to be an optimistic assumption. However, the clientele will be handicapped, mostly severely so, and it is a fair assumption that they will all be qualified for Medicare or Medicaid assistance.

Income estimates are based on minimum estimated direct client hours.

Income shown as supervision fees is a result of the fact that both Nancy Belohavek and Jennifer Ransom are enrolling in a Master of Social Work program at Lindenwood College. Each will be paying $200.00 per trimester for three trimesters for supervision on this project which will be written up as part of their Master's work.

MONTHLY PROJECTION

actual cash outlay

Monthly salaries @ ¼ time to start for two therapists	$481.50
Monthly room rental for office space	150.00
Monthly telephone charge	30.00
Monthly total cash outlay only	661.50

To meet actual out of pocket monthly expenses above what is currently already being paid in Suite 400 monthly budget would require seeing an additional three clients twice a week.

Projected income, three clients, twice a week, 1 month	840.00

Assuming Start Up costs of $2,785.00, monthly cash outlay of $661.50, starting program at ¼time, and 60 day lag between billing and collection, estimated breakeven point on out of pocket monthly expenses is 60 days, estimated recovery of start up cost point is 150 days. That projection is based on minimum intervention with seven clients.

Committments for referrals has already been obtained from Topeka/Shawnee County Health Department, Stormont Vail Hospital and Dr. Glenn Bair. Area physicians have not yet been contacted for referrals.

Based on the proposed program and discussion of it, we are currently holding four referrals to begin the program if permission to implement is given by the board: 1) a referral from Dr. Twemlow; 2) a referral from Unified Court Services; 3) a referral from Dr. Glenn Bair; and 4) a referral from Elizabeth Kuhbler Ross. All referrals are Title XIX funded except the last, and he is a private-pay imobilized client able to pay $50.00 per hour plus cost of home visits.

PROGRAM INCOME

projected on an annual basis

Income from Client Billing

Evaluation 24 patients, 3 hrs. per week x 3 weeks @ 35.00	$ 7,560.00
Individual Therapy	
24 patients, 1 hr. per week x 24 weeks @ 35.00	20,160.00
16 patients, 1 hr. per week x 4 weeks @ 35.00	2,240.00
8 patients, 1 hr. per week x 24 weeks @ 35.00	6,720.00
Group Therapy	
16 patients, 1 hr. per week x 4 weeks @ 7.00	448.00
Total Estimated Income from Client Billing	$ 37,128.00
Income from Other Sources	
Supervision Fees	1,200.00
TOTAL ESTIMATED INCOME FROM ALL SOURCES, FIRST YEAR	$ 38,328.00
TOTAL FIRST YEAR PROGRAM COST, INCLUDING START UP	23,664.40
PROJECTED FIRST YEAR PROFIT	$ 14,663.60

Assumptions and Explanations:

Expenses

Estimates are liberal, rather than conservative. Expenses shown assume rental of additional office space adjacent to current Suite 400 facilities rather than partitioning currently available space. In some instances, (i.e. purchase of office equipment) optimum rather than essential purchase is assumed.

Income

Estimates are conservative, rather than liberal. Hours shown represent taking two groups of 12 patients each through a very specifically programmed 6 month process. Individual varience within the program will require more, not less direct client hours. 6 months represents minimum participation - in the pilot project upon which this is based, one pt. required 11 months of participation to complete the entire process.

continued

INTERVIEW SHEET - GUIDELINES

* Expectations:

Where is the person presently:

Current significant person:

Current Financial situation - medical Insurance

Current Physical condition - Specifying Disabilities

Concept of recovery

Concept of illness

* Living Arrangement:

Where

Withwhom

* Current Care Required:

Who is providing this care

* Activity:

Energy Level - Previous and present

Activities & Exercise

How Often

What Kind

How much is possible with the disability

INTERVIEW SHEET - GUIDELINES

* Work:

Previous Jobs held - Time Devoted to a Job

Present Job - Time Devoted

If Presently Unemployed are there Future Plans for a Job?

What are they

How do they feel about them

Can They be met

* Diet:

Present eating habits

Substance Use

Coffee	Drugs
Cigarettes	Alcohol

* Sleeping Patterns:

* Dreams & Family Life:

* Prevailing Mood/Emotion:

Depression	Assertion & Aggression
Helplessness	Sense of Humor
Hopelessness	Tone of Voice
Body Language	Body Image
Apathy	Self-Direction
Reality testing	

INTERVIEW SHEET - GUIDELINES

* Fears

Are you afraid of anything

Phobiais

* Sexuality

Present involvement

Is the disability causing any problems with their sexual life

Previous sexual involvements

KEEPING AN INTROSPECTIVE DAILY JOURNAL

This is a useful method for personal self-exploration and growth. It is a brief daily account of you. It is your private self shared only with yourself and your counselor. This will be yours to keep, if you wish. Many people find it both helpful and interesting to go back over their journals written months or even years back to see the changes they have made. There are many benefits from keeping a daily journal. It makes you focus upon developing yourself as well as understanding yourself and others more clearly.

Your journal may be written or recorded on cassette tapes depending upon which is easiest for you. The most important thing to focus upon is the content of your journal. Though you may include external significant events, try to focus upon internal themes.

You will find your journal useful as a guide in helping you understand how you operate. You will become more aware of how you work through and resolve problems. Your journal will also stimulate your inner creativity if you learn to open up and let your thoughts and feelings flow. You may find the journal very helpful in letting out angers and tensions directed at others and yourself. Some people find they can work on overcoming shyness using this sort of a journal. Basically the journal allows you to express yourself, take chances, and increase your awareness of yourself by looking at yourself. Feel free to add personal touches to your journal by including pictures, music, or poems you feel are important to you.

There are some areas to focus upon in your journal. You may add your own too. Remember to keep each day short yet meaningful.

Peak Experiences: High or deep experiences of love, peace, joy, revelations.

Emotional Awarenes: Expression of your feeling - both positive and negative

Hangups - Personal limitations or weaknesses, which you noted and want to work on.

Dreams - Description of your night and day dreams. Pay attention to the imagery and colors in these. Also include your fantasies.

Identification: Who do you identify with/who do you disidentify with? How well can you answer the question "Who Am - I?"

Bright Ideas: Ideas that excite you and inventions.

Remember to put something into your journal each day and date each entry. Remember the privacy of your journal enables you to be very open and introspective.

DATE:	SUNDAY	MONDAY	TUESDAY	WED.	THURS.	FRI.	SAT.
Diet							
Emotions: Sad							
Happy							
Depressed							
Social Outings							
with friends							
with son							
alone							
had a friend over							
hrs. slept at night							
naps							
minutes of exercise							
heat lamp							
wrote in journal							
hrs. of reading							
tapes							
felt much physical pain							

AUTOBILOGRAPHY

CHILDHOOD

Earliest memories
Relations with parents
Relations with siblings and friends
Living arrangements
Health - Illnesses
Outstanding events
Sleep patterns - nightmares - early fears
Favorite toys or play things
Your place in the family i.e. oldest, youngest
Number of siblings
Losses of loved ones

GRADE SCHOOL PERIOD

School Adjustment
Religion
Losses
Hobbies/what kind of recreation or relaxation activities do you enjoy?
Illnesses
Fantasies
Recurrent dreams
Outstanding events
Friends
Pets
Role modes, people you would like to be like
Superstition
Preminisions

TEENS

Physical development
Education - Religious and School
Health
Hobbies, sports, recreation
Economics
Religion - values and morals
Sexual experiences and sexual education
Friends
Fantasies and dreams
Outstanding events
Role models
Family
Losses
Heroes

ADULTHOOD

Vocational goals & Life goals
Job Relationships
Social Activities
Friends
Interests and hobbies and relaxation activities
Family

ATUOBIOGRAPHY (Continued)

ADULTHOOD

Spouse - marital experiences
Initimate Relationships
Children
General outlook upon life
Health
Losses
Special Events

1. If you had to live your life over again what would you change.

2. What time of your life has been the most pleasant? - Why?

3. What time in your life has been most unpleasant? - Why?

4. How does religion effect your every day life?

NAME: _____ DATE: _____ AGE: _____ SEX: _____ SSN: _____

Last Name Initials

Please complete the following questions by checking the column which most closely represents your overall feeling. Remember there are no right or wrong answers to the questions.

	OFTEN	SOMETIME	RARELY	NEVER
1. I think about my own death.				
2. I think about the death of loved ones.				
3. I think about dying young.				
4. I think about the possibility of my being killed on a city street.				
5. I have fantasies of my own death.				
6. I think about death just before I go to sleep.				
7. I think of how I would act if I knew I were to die within a given period of time.				
8. I think about how my relatives would act and feel upon my death.				
9. When I am sick I think about death.				
10. When I am outside during a lightning storm I think about the possibility of being struck by lightning.				
11. When I am in an automobile I think about the high incidence of traffic fatalities.				

(continued next page)

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			STRONGLY DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	STRONGLY AGREE	
12. I think people should first become concerned about death when they are old.							
13. I am much more concerned about death than those around me.							
14. Death hardly concerns me.							
15. My general outlook just doesn't allow for morbid thoughts.							
16. The prospect of my own death arouses anxiety in me.							
17. The prospects of my own death depresses me.							
18. The prospect of the death of my loved ones arouses anxiety in me.							
19. The knowledge that I will surely die does not in any way affect the conduct of my life.							
20. I envision my own death as a painful nightmarish experience.							
21. I am afraid of dying.							
22. I am afraid of being dead.							
23. Many people become disturbed at the sight of a new grave but it does not bother me.							
24. I am disturbed when I think about the shortness of life.							
25. Thinking about death is a waste of time.							

(continued page 3)

			STRONGLY DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	STRONGLY AGREE	
26. Death should not be regarded as a tragedy if it occurs after a productive life.							
27. The inevitable death of man poses a serious challenge to the meaningfulness of human existence.							
28. The death of the individual is ultimately beneficial because it facilitates change in society.							
29. I have a desire to live on after death.							
30. The question of whether or not there is a future life worries me considerably.							

	of the time	the time	of the time	of the time
1. I feel down-hearted and blue				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping at night				
5. I eat as much as I used to				
6. I still enjoy sex				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to do				

Depression Rating

2. Do you believe that you can stop yourself from catching a cold?

3. Are some people just born lucky?

4. Most of the time do you feel that getting good grades meant a great deal to you?

5. Are you often blamed for things that just aren't your fault?

6. Do you believe that if somebody studies hard enough he or she can pass any subject?

7. Do you feel that most of the time it doesn't pay to try hard because things never turn out right anyway?

8. Do you feel that if things start out well in the morning that it's going to be a good day no matter what you do?

9. Do you feel that most of the time parents listen to what their children have to say?

10. Do you believe that wishing can make good things happen?

11. When you get punished does it usually seem it's for no good reason at all?

12. Most of the time do you find it hard to change a friend's (mind) opinion?

13. Do you think that cheering more than luck helps a team to win?

14. Did you feel that it was nearly impossible to change your parent's mind about anything?

15. Do you believe that parents should allow children to make most of their own decisions?

16. Do you feel that when you do something wrong there's very little you can do to make it right?

17. Do you believe that most people are just born good at sports?

18. Are most of the other people your age stronger than you are?

19. Do you feel that one of the best ways to handle most problems is just not to think about them?

20. Do you feel that you have a lot of choice in deciding who your friends are?

N.-S. Adult I.E. Scale

Introverted

Unrevised

[illegible] much to do with what kind of grades you got?

23. Do you feel that when a person your age is angry at you, there's little you can do to stop him or her?

24. Have you ever had a good luck charm?

25. Do you believe that whether or not people like you depends on how you act?

26. Did your parents usually help you if you asked them to?

27. Have you felt that when people were angry with you it was usually for no reason at all?

28. Most of the time, do you feel that you can change what might happen tomorrow by what you do today?

29. Do you believe that when bad things are going to happen they just are going to happen no matter what you try to do to stop them?

30. Do you think that people can get their own way if they just keep trying?

31. Most of the time do you find it useless to try to get your own way at home?

32. Do you feel that when good things happen they happen because of hard work?

33. Do you feel that when somebody your age wants to be your enemy there's little you can do to change matters?

34. Do you feel that it's easy to get friends to do what you want them to do?

35. Do you usually feel that you have little to say about what you get to eat at home?

36. Do you feel that when someone doesn't like you there's little you can do about it?

37. Did you usually feel that it was almost useless to try in school because most other children were just plain smarter than you are?

38. Are you the kind of person who believes that planning ahead makes things turn out better?

39. Most of the time, do you feel that you have little to say about what your family decides to do?

40. Do you think it's better to be smart than to be lucky?

QUESTIONNAIRE FOR PHYSICALLY DISABLED AND MEDICALLY ILL

NAME: _____ SEX: _____ EDUCATION: _____

AGE: _____

Briefly answer the following questions in the space provided.

1. Previous counseling _____ with who _____
2. Describe any physical disability _____
3. Describe medical problem(s) _____
4. Describe the person closest to you _____
5. Where do you live _____
6. Are you employed _____
7. Do you remember your dreams _____ How often _____
8. How many hours do you sleep at night _____
9. How many hours do you sleep during the day _____
10. Do you have nightmares? _____ How often _____ About What _____
11. Are you religious _____ describe _____
12. Do you dream of flying or falling _____
13. Do you dream of being killed or dead _____
14. Do you have reoccurent dreams _____
15. What medications do you take _____ (how often) _____
16. What kind of entertainment do you like _____
17. How many hours a week do you read or listen to tapes _____
18. How many hours a week do you spend with friends _____
19. How many hours a week do you spend with family _____
20. How many hours a week do you spend with pets or plants _____
21. How many time per month do you visit an M.D. _____
22. Are you troubled by your weight _____ (if so - why) _____
23. Do you have any hobbies or crafts _____ (describe) _____

QUESTIONNAIRE OF THE PHYSICALLY DISABLED
AND THE MEDICALLY ILL

NAME: _____

AGE: _____ SEX: _____

	NONE OF THE TIME	SOME	MOST	ALL
I feel happy				
I fee lonely				
I feel scared				
I feel pleasant				
I feel nervous				
I feel calm				
I feel insecure				
I feel angry				
I feel sad				
I cry easily				
I get irritated				
I believe in life after death				
I get bored				
I drink coffee or tea				
I smoke cigarettes, pipes, cigars				
I do exercise				
I feel sluggish				
I have trouble motivating myself				

QUESTIONNAIRE OF THE PHYSICALLY DISABLED
AND THE MEDICALLY ILL

NAME: _____

AGE: _____ SEX: _____

	NONE OF THE TIME	SOME	MOST	ALL
I enjoy music				
I like being touched				
I am bothered by Pain				
I am troubled by my self-concept				
I like surprises				
I enjoy adventures				
I like to take risks				