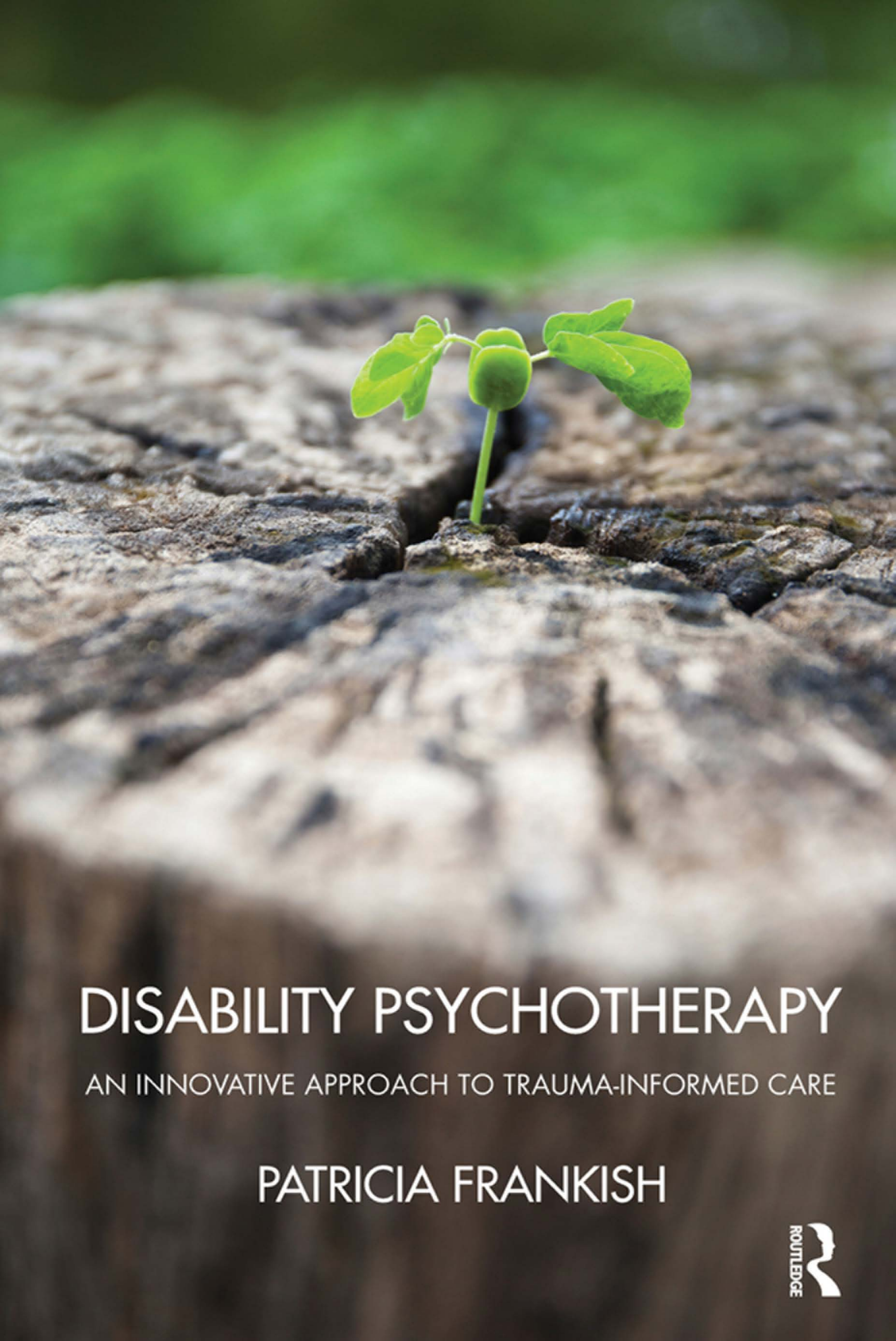

DISABILITY PSYCHOTHERAPY

AN INNOVATIVE APPROACH TO TRAUMA-INFORMED CARE

PATRICIA FRANKISH

DISABILITY PSYCHOTHERAPY

DISABILITY PSYCHOTHERAPY

An Innovative Approach to Trauma-Informed Care

Patricia Frankish

Routledge
Taylor & Francis Group
LONDON AND NEW YORK

First published 2016 by
Karnac Books Ltd.

Published 2018 by Routledge
2 Park Square, Milton Park, Abingdon, Oxon OX14 4RN
711 Third Avenue, New York, NY 10017, USA

Routledge is an imprint of the Taylor & Francis Group, an informa business

British Library Cataloguing in Publication Data

A C.I.P. for this book is available from the British Library

ISBN-13: 9781782203162 (pbk)

Typeset by V Publishing Solutions Pvt Ltd., Chennai, India

CONTENTS

ABOUT THE AUTHOR vii

PREFACE ix

CHAPTER ONE
Winnicott 1

CHAPTER TWO
Bowlby 19

CHAPTER THREE
Margaret Mahler 31

CHAPTER FOUR
Measuring the emotional development of intellectually disabled adults 47

CHAPTER FIVE
Other influences 57

CHAPTER SIX
Designing interventions 63

CHAPTER SEVEN
The house-tree-person test 75

CHAPTER EIGHT
Using the object relations technique with people with intellectual disabilities 83

CHAPTER NINE
Comprehensive assessment of the individual 89

CHAPTER TEN
Evaluation of the impact of the systemic model of trauma-informed care 97

CHAPTER ELEVEN
Evaluation of the impact of individual psychotherapy 109

CHAPTER TWELVE
Comparison with other therapeutic models 115

CHAPTER THIRTEEN
Future use of the model 121

REFERENCES 127

INDEX 133

ABOUT THE AUTHOR

Patricia Frankish is a Clinical Psychologist and Psychotherapist with many years of experience in the field of disability. Her doctoral study established a method for measuring emotional developmental stages in people, who had suffered trauma, and consequent interference in the developmental process.

She is from Lincolnshire and after working in a range of settings and spending six years in North Yorkshire and Teesside, she has settled back in Lincolnshire with her own business in partnership with her daughter. They specialise in providing services for people with complex needs, using the model that Pat has developed. They offer direct support, training and therapy, either as a package or one component. For those who need it they also provide accommodation.

Pat has been President of the British Psychological Society, was a founding member of the Institute of Psychotherapy and Disability and is an active member of her local Church and community.

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

PREFACE

This book has come to be written after a period of many years of trying to bring together the different theoretical positions of traditional psychoanalysis, plus a traditional understanding of learning disability and of my own experience. It seems appropriate to begin by placing this book in time and space although taking, to some extent, a post-modern position of accepting that time and space are constantly changing, constantly moving, and what is real for the individual is, just that, real for the individual. This work constitutes a collection of many hours of thinking, reading, soul searching, teaching, training and supervising, all based on clinical work with real people. The main teachers throughout this whole process have been the people: the clients who have put their trust in me as a therapist, and have demonstrated the enormous core strength that they have in the face of great adversity. Valerie Sinason (1992) has already written extensively about people with learning disabilities and the similarities and realities of their lives as they reflect on the basic human condition, the condition of being human as I see it. The condition of being human is constantly around for people with learning disabilities. Their lives have been, for many of them, almost inhuman, in that services for many years have treated them as a less than human group, and indeed in my early days of contact with the client group, they were referred to as sub-normal, in other words, not normal, below normal.

I want to say a little bit about my own life experience because that contributes to the way that I have studied and learned from other people's work, and have brought it together to the position that I now hold in relation to the work that I do. I grew up in the grounds of an old institution, in fact, it was called an institution when I was very small and became a hospital under the new National Health Service after 1948. My parents both worked at this hospital. It was a small 200-bed hospital in a rural community. As with many of these old institutions it was built in open countryside away from the general population. This particular hospital had been built by a benefactor as a "house of industry" prior to the workhouse days. It was converted to a workhouse at the time of the workhouse being necessary and served quite a large geographical area at that time. There are reports that indicate that towards the end of its days as a workhouse there were a number of people who were imprisoned in chains or locked into rooms because they were considered to be mad or certainly not able to look after themselves or be free to live in the community. And so, it was almost by default, as with many workhouses, that it became an institution for people who were at the time referred to as mentally defective. The term was later changed to mental sub-normality and that was the term that was in use in the days when I was a child. My mother was qualified as a registered nurse for the mentally subnormal and was a ward sister for much of my childhood. My father became the clerk and steward of the institution just before the Second World War and at the time of it being changed in to a hospital, he became the hospital secretary. They set an example for me, I think, of commitment, in that both of them stayed looking after people with learning disabilities until they retired. So, my father in fact served 46 years as the hospital secretary and my mother something less than that because she took time out to look after me, my brother, and my sister.

The hospital itself was, in the 1950s and 1960s, relatively self-sufficient in that there was land on which vegetables were grown and pigs were kept, and food generally was produced for the use of the hospital. Many people who lived there actually worked in the laundry or in the kitchen and were responsible for the cleaning and maintenance of the establishment. There was a rule at that time that men and women were not allowed to be in the same hospital because of the risk that they would get into relationships so in the hospital where I lived there were women and boys, but no men, which meant that the heavy farm work was probably less than it would have been at a different hospital that had catered for men.

My memories are of the women being dressed in very similar clothes. There were several shades of gingham, there was green and blue and red if I remember rightly and these dresses that the women wore were lined with a heavy cambric material. When I think now what it must have been like to wear, I find it quite distressing. They were herded together at mealtimes in big dining rooms. The huge rooms were heated by coke-burning stoves with big fire grates and fireguards at the end of each large room.

These are childhood memories of things that have stuck in my mind from those early days. I have very clear memories of my mother being a sister on a ward for children and seeing these little children, mostly boys—in fact initially they were all boys, girls weren't introduced until the 1970s I think—and these little boys in very serious states of organic brain damage, children with huge heads from untreated hydrocephalus, children who self-injured to such an extent that they were black and blue all of the time and there was very little that could be done to stop them. One little boy in particular I remember had a cot with a lid on because it was the only way that he could be contained at all. There were no wheelchairs for the children, there weren't even any chairs for the children, and on a sunny day, the cots would be wheeled out on to the grass so that they could have some fresh air. Again memories of a child.

These were situations I didn't really understand as a child. I knew that my mother worked hard. I knew that most of the people who lived at the hospital seemed quite content, we regularly socialised with them at the cinema that was brought in on an evening once a week, at the dances that happened again every week, at the tuck shop where we bought our sweets, and they bought their sweets. It seemed fairly normal to me because it was all I had ever known. I was teased at school for living at the loony bin, something that I didn't understand because I didn't know what loony meant and I didn't see the people that I saw every day as loony until somebody explained to me what it meant. But as I grew older I became aware that there were some people who lived in the hospital who were not content and who were seen as difficult, a nuisance, or bad and sometimes seen as dangerous.

I became aware of discussions about whether somebody needed to be sent to Rampton Special Hospital, which was the special hospital serving the area where I lived. I had this spectre, again a child's perspective, of Rampton Hospital being the last place on earth that anybody would ever want to go. The other thing I became aware of was that there were one or two people who occasionally caused a great deal of damage and threw tables and chairs and became very disruptive and destructive. They were given injections of some drug which I was told was haloperidol or paraldehyde which was used to control and calm them down.

I became aware also, as I moved into my teens, that the wards had what were called side rooms, what now would be called seclusion rooms, and these rooms were bare rooms with no handles on the inside of the door and people were put into these side rooms or were threatened with the side room if things were not going well. So as I became a teenager and moved through my teenage years I became somewhat more confused about whether or not this was the right thing to do for people to be looked after in this way and I began to question more and more whether in fact they would choose to live this way.

As it happened, I left home, following a reasonable level of discomfort with my parents and siblings, at sixteen, and moved away. I still went home every weekend and was aware still of changes, things that were developing, movements that were happening. Changes in the population of the hospital, in that it became acceptable in the 1960s that men and women could live in the same hospital and there were more girls admitted. The other thing that happened with this particular hospital was that they began to take more of the people with profound physical as well as learning disabilities so there was an increase in the population of very, very disabled people.

My own life took a turn in that I married very young and had three children. I remember very, very clearly during all three pregnancies thinking to myself that I mustn't have one of the children like the ones my mother looked after, but had no real understanding perhaps of what it could have meant. Nor were we in those days involved in any testing or screening process that would have indicated that we might have a disabled child. I was certainly familiar with children with Down Syndrome, hydrocephalus, spina bifida and some of the more distressing syndromes as well as some of the children who during the 1960s were very much experimented on medically in attempts to correct some of their difficulties. Some of the children that I knew did not live to the age of twenty.

In 1973, my marriage failed and in those days, there were very few choices for women with three children who needed a place of safety. The only real choice was for me to return to the parental home. My brother and sister had left to lead their own lives, my parents were on their own in a four-bedroom hospital house, and they had room for us. It was not an easy decision but we went, the four of us, and returned to live in the grounds of the hospital. I was in a position also of having no money and three dependent children and the obvious place to work was in the hospital.

For all the experience that I'd had of the place I had never worked there and faced the possibility with some trepidation. It was vitally important to me and my parents that no position should be created for me. I was appointed to a vacant position of "play leader". The job involved working with sixteen very disturbed adult women who were on a back ward where they were not allowed to leave the ward to go to occupational therapy or on outings because of their very difficult behaviour. They had a sort of pen that they could go into outside to get some fresh air and walk about but, generally speaking, were confined to the day rooms and the dormitories of the ward. I was given, as equipment to start this job, a diary, a notebook, a couple of pens, a ruler, a pencil, and a list of the 16 people—no toys, no materials, no ideas—and I suppose I was quite overwhelmed by this initially.

But, anyway, I went to meet the sixteen individuals and realised in fact their level of ability was less than my own children's in many ways. A number of them couldn't speak, all of them were ambulant, they could all run, and they could all fight, and they had a variety of antisocial behaviours. They were generally very unpopular with the nursing staff. I don't know where the idea came from because at that time, I had no scientific training at all but something told me that I had to find out what they could do. I had to try and find out where they all were in terms of level of ability in relation to each other.

So, I went to the occupational therapy department and borrowed one or two bits of equipment. These were some stacking cups, a screwing and unscrewing rod, a pencil and paper, and a nine-piece jigsaw. I took these things along to the sixteen people individually to see what their level of ability was on these tasks. I made a record of what they could actually manage and then divided them into four groups of four.

I secured the use of a little room at the end of the ward and decided that I would work with four at a time in this little room.

It became very obvious that I couldn't do anything with them unless I had some equipment and I managed to beg, borrow, and steal the first set of equipment, mainly from occupational therapy. I then managed to secure a small sum of money from central resources to buy some other bits and pieces of equipment. What happened, basically, was that the sixteen people each got an hour a day of one to four attention as opposed to having the whole day with, at best two to sixteen and frequently two to forty.

It was dramatic, the effect on these individuals and it was something that quite overwhelmed me at the time. They were people who had a very, very miserable and deprived life, their basic needs were met, they were clean and fed and they had somewhere to sleep but they had nothing to do and they had no joy in their lives at all. Given the opportunity to experience painting, drawing, playing, playing ball, and listening to music with a much better ratio of staff to patient resulted in some real achievements, some real benefits in terms of learning but even more so in terms of reduced antisocial behaviour.

It was about this time that a clinical psychologist in training came to our hospital as part of her placement. She came to our hospital one day a week for six months and it was obvious to her that the person who would be more likely to be able to work with her was me. She came and joined my groups initially and then we started to do some specific work with her with specific behaviour problems with individuals. She taught me how to work out whether somebody, through their own behaviour, was actually seeking attention or seeking affection and pointed out how important it is to know the difference. It's something that's stayed with me to this day because I hear so often people saying, "Oh, they're just attention seeking", and I get so cross because people wouldn't seek attention if they got enough attention. Quite often people are in fact desperately looking for affection and don't know how to get it.

The next stage of my working life led me into the development of a social training unit within the hospital to which many of my so-called hopeless cases did eventually graduate. They were able to attend sessions off the ward as they had become able to concentrate, to pay attention and use periods of time of up to an hour, enjoy them and, equally, benefit from them and learn new skills. There's one particular lady who stays in my mind very, very clearly who had a very, very antisocial behaviour of leaving faeces all over the hospital grounds. She would also wail and scream and make an awful lot of noise and was considered to be a very, very difficult, unreasonable, unlikeable woman. What we found in fact was that she was quite intelligent and that once she had something to do, something to interest her, some activity to take part in, she became almost a star pupil. The antisocial behaviour disappeared when she was able to gain appropriate adult-to-adult contact.

During the time of being in the social training unit, I became responsible for education. This was a very basic level of education, but I had also been asked if I would do some basic literacy work with some of the more able people who were on a different ward. I did that one evening a week for the education authority so I started to do a bit of very primary education with the more disabled people. I remember working with a lady with blocks and counting. If she had four blocks, she could add and subtract two plus two, two from four, two plus one, one from three. She was quite happy manipulating the blocks if she had four, but if you gave her five blocks she couldn't do anything with them at all, she couldn't even do the sums she had done with the four blocks. This absolutely fascinated me. I thought what is it about this lady, what is it about the way her brain works that won't allow her to retain the information about four if the message is confused with five. That was probably one of the most significant points at which I decided that I wanted to be a clinical psychologist. I wanted to understand what it is about the brain that lets it do some things and not others, that allows for pockets of ability within a very damaged brain at the same time as having huge areas of disability? Then to go back to the lady with the antisocial behaviour I mentioned a few paragraphs back, what it is about somebody that causes such antisocial behaviour and works against the possibility of making real human contact?

Around this time, I became quite ill myself in that I had an attack of acute arthritis which attacked nearly all of my joints and led to me being hospitalised on complete bed rest. The attack lasted eleven months. My children were largely looked after by my parents, it was a time of real shock for me, the time when I had to be dependent, something that I wasn't used to. A time of realising what it is like to be disabled, although for me it was temporary, but to realise what it was like to not be able to do what you want to do and to have to wait for things to come to you. The five weeks I lay on the bed in the hospital knowing I couldn't wash, go to the toilet, or eat unless somebody came within reach for me to ask then. Even when I had asked them, I had to wait for them to come back and attend to whatever it was that I needed. It gave me just a little bit of insight into what it must be like for people to spend the majority of their lives just waiting for something to happen, unless, of course, they make a tremendous fuss. Then something does happen, but usually it can become quite punitive.

The arthritis left me with permanent knee damage and very weak hands and wrists which meant that I could no longer work in a job that required such a high level of physical ability as the one I was doing. So, I had to leave the hospital and I became for a couple of years a registrar for births, deaths, and marriages. A very strange occupation but again it gave me an insight into people at times of major change in their lives, at the time when someone dies, the time when someone's born and the time they get married. Although as registrar you don't spend a lot of time with the people that you see, you are certainly face to face with very real emotion with everybody that you do see.

During the time that I was registrar, I continued my studies and planned to get a degree with the Open University. I had maintained contact with the clinical psychologist who had visited the hospital and she said to me one day, "Why don't you go to university?" to which I replied that people like me, that is, adults with growing children, can't go to university. Also, I'd left school without A levels and could not see that I had the entry requirements. Anyway, she encouraged me to apply and I wrote to Professor Alan Clark at Hull University, explaining what I wanted to do and why. He wrote back, by return of post, which was something that stays in my mind, inviting me to go to see him. I went to see him and he offered me an unconditional place to study special psychology at the University of Hull.

I then discovered, much to my surprise and delight, that my local authority in those days would pay me a maintenance grant for myself and my three children, and my travel expenses to allow me to go to the university without having to leave the children with someone else or move and take them with me. It felt like all my birthdays had come at once and it was a tremendous opportunity.

I was in my late twenties by this time, I had three growing children, constant financial difficulties, my physical health was below par, but I had an opportunity to do something I really wanted to do. So, I did my degree at Hull. I used to travel by car to the station, by train to the boat, by ferry across the Humber and by bus to the university. It