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Some Concluding Notes - Healing the Split Between Psyche and Social: Constructions and Experiences of Disability

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This special issue has attempted to think about the relationship between subjective experience and social context in theorising disability. Many of the papers examine the dynamics between therapist or counsellor and client. They suggest that in order to be able to have an inclusive counselling or therapeutic practice that is able to engage empathically with all clients, counsellors and therapists need not just an understanding of unconscious processes and therapeutic technique. They also need a certain cultural literacy and political education around disability issues.

In terms of cultural literacy, talking treatments depend upon developing a shared language which in turn requires shared cultural resources. So often therapist and client do not become conscious of the significance of sharing a culture until this is absent and misunderstandings are exposed. Because of the radical social exclusion of disabled people from mainstream activities, it has often been the case that disabled people have developed an alternative shared culture of which mainstream society remains ignorant. This is particularly the case among Deaf communities (Padden and Humphries, 1988), but also among those disabled people who have been segregated into institutions (Hunt, 1981; see also the film and book *Scallagrigg*). Disabled people facing similar kinds of barriers share a perspective on the world not always afforded to non-disabled people. If the therapist is not disabled, it is important for them to acquire such literacy through engagement with disabled people's communities. Sometimes the best way of developing a cultural literacy about diverse experiences of disability is to explore disability art and performance and read narrative accounts by disabled people.[1] The argument that the difficulty of cultural differences can be dealt with if the counsellor is disabled does not provide a panacea since different impairments lead to different socio-cultural experiences.

In addition to developing a cultural literacy about the meanings and experiences of the range of disability experiences, therapists need to have a political understanding of the construction and treatment of disability within contemporary society. That is, an understanding of the way barriers produce disability and the civil rights and access issues which are a central part of institutions.

Stuart Hall cites the most frequently asked question of migrants. 'Why are you here?' and 'When are you going back home?' (1990, 44). In the same vein, disabled people are asked the equivalent question, 'How did you get like that?' and 'Can you be cured?'. Both questions interpolate an 'outsider', someone not like me, whose existence presents a problem to me. Disability is thus a social construction built into our social world and then invested with fears and fantasies that operate at a cultural, an interpersonal and ultimately an intra-psychic level.

In 1994 I set up, organised and taught a Masters Programme in Disability Studies located at the Centre for Psychotherapeutic Studies, Sheffield University, England. The Disability Studies programme ran alongside Masters courses in Philosophy, Psychiatry and Society and in Psychoanalytic Studies. In different ways, all these courses undertook to bridge the social-psychic split in thinking about disability. They aimed to critically examine social constructions, institutional processes and bodies of knowledge and the way in which subjectivities were constructed and lived.

The Centre for Psychotherapeutic Studies was located within the medical school of the University. This placed us all in a paradoxical position. We were all engaged in challenging medical power and knowledge and putting forward a range of alternative ways of conceptualising mind/bodies such as anti-psychiatry, talking therapies and political activism. Yet we were, on a daily basis, working alongside and in close contact with health care professionals who were engaged primarily in treating individuals. All three courses tended to attract a large number of health care professionals, although Disability Studies attracted roughly a third of its intake from disability activists, allies and educators.

All three courses produced an interesting cross-fertilization of experiences and perspectives. Many students expressed ambivalence towards psychotherapy and counselling. Although they had chosen to study in a Centre for Psychotherapeutic Studies, some students had had experiences of 'mainstream' therapy and counselling which were traumatic and painful. Many described an experience of feeling reduced, pathologised and shamed. For example, some students described their experience of physical pain being invalidated. Some felt that counsellors had asked intrusive questions or seen all their experiences purely in terms of their impairment rather than allowing them the space to think about relationships or other concerns they brought. Some focused on coming to terms with the limitations their 'impairment' placed on them at the expense of helping them to develop a sense of entitlement about what life could offer them.

All these criticisms of health care and some therapists and counsellors are shared by many disabled people and are well documented in the literature (Lenny, 1994; Wendell, 1996). However, many other students also had quite positive experiences of counselling and they did not reject the psychological principle of reflecting on experience, but rather objected to some disablist theories and practices of particular professionals. There seemed a clear gap in writing that addressed both social and psychological approaches.

In this paper I set out to explore some of the issues that counsellors and therapists need to reflect on in order to develop an inclusive practice. For those therapists who are not disabled, the question of what they need to know about disability may not have even risen. Disability issues are certainly not raised in UK training in the way that other forms of social exclusion around gender or 'race' are. There are large training organisations for thinking about racialization and cultural concerns (such as NAFSIAT) and gender (such as the Women's Therapy Centre) within counselling and therapy, but no comparable organisations that look critically at disability.

Where counsellor and therapists do express an interest in thinking about disability, the focus is often on:

The nature and implications of specific impairments. In other words, they are hoping to develop an 'impairment literacy'.

The kind of 'social etiquette' to adopt so as not to offend disabled clients. For example, what language should be used, what do I do if I have difficulty understanding a client with a speech impairment.

The psychological consequences of disability. How do people come to terms with acquiring an impairment? What effect might this have on a person's self-esteem?

Therapists are particularly interested in this latter point. They often use a bereavement model to think about how people might come to terms with becoming disabled (with its stages of anger, despair and readjustment). At other times, a model of infant development is used to think about the sensory, motor and intellectual differences seen through an infant development model. So, for example, writers such as Kenneth Wright (1991) and Selma Frieberg (1987) offer analyses of the consequences of congenital blindness for attachment and ego development.

Such explorations may well be important. But what gets left out in equation is:

The conscious and unconscious fears and fantasies about disability which shape the way in which we think about ourselves and others whether we are disabled or not.

The tools to think critically about the way disability is constructed by the social and cultural environment in which we live.

Related to these two points, the focus is on the disabled client or potential disabled client (that is, the client most mainstream counselling services do not get to see). A client centred orientation (which also finds a space for therapist issues) is understandable given the dyadic nature of the work.

However, there is very little reflection on their own institutional affiliations and unconscious feelings about disability.

When thinking about disability, it is usually understood in terms of the disabled client rather than the disabled therapist. Generally, disabled people are conceptualised as recipients rather than providers of services (Morris, 1993). This point is brought home most powerfully by Bliss in her powerful challenge to one of the prestigious London psychoanalytic psychotherapy trainings (1994) for refusing to accept her application to become a training therapist. Her organisation explained that her visible impairment rendered her an object of pity to her clients and would make it difficult for them to express hostility to her. However, as Bliss points out,

> If there is an innate fear of disability, of physical difference, might not the opportunity to work with a disabled therapist help the student to confront and work through those fears and preconceptions and thus be an excellent preparation for helping the physically disabled people he or she is likely to meet in practice? And when the disability is there to be seen it can be worked with (1994, 117).

Bliss argues that non-disabled patients unconscious fears and fantasies about disability are often projections of their own (also unconscious) sense of damage. Disabled people function as a recipient of unbearable and disavowed feelings. Of course, there is a cultural context which explains why disabled people are, in the words of Tom Shakespeare (1994), 'Dustbins of Disavowal'.

Disability within contemporary cultural is often used as a metaphor for damage, loss or evil (Marks, 1999). These images of disability make disabled people into the unwilling recipients of anxieties with which most people struggle, whether they are acceptable, loveable, whole and good. There is so often a failure to see the extent to which non-disabled people project their own unbearable feelings into disabled people who are then feared or pitied. This means that to some non-disabled people, disabled people can be potentially threatening to their sense of bodily and intellectual security. Unlike other socially devalued groups (such as certain ethnic minorities), who are relatively safely constituted as 'Other', disability is more personally threatening, since everyone can become disabled. Thus, the common questions I outlined above often originate from the anxiety that the non-disabled counsellor/therapist has in managing the differences between themselves and their clients.

Much psychoanalytic writing on physical disability suffers from an uncritical and 'functionalist' orientation which fails to acknowledge the wider social and cultural context in which disability is produced. There is a failure to recognise the way in which the built environment, social structures, technology, and cultural values construct disability (Davis, 1996; Marks, 1999).

Some activists have argued that one solution is for disabled people to provide specialist therapy to other disabled people. Many clients feel safer and would prefer to see someone who they identify as having a similar experience to themselves. There are some groups, such as Deaf people, who will need a sign language user and prefer not to use a translator. However, this cannot be the answer for all disabled people. Some disabled people may not see their 'disability' as central to their identity. They may not feel they have much more in common with people with different impairments to themselves than with people who are not disabled. Finally, as Bliss (1994) points out, the ability to deal with difference between therapist and client should be grist to the mill for clinical work.

What is needed is a more sophisticated understanding of the meanings and experiences of disability within the analytic encounter. For this, the focus needs to be not just on disabled people's unconscious experiences and investments, but also non-disabled people's investments. The consulting room is not a hermetically sealed bubble containing the inner worlds of therapist and patient. The analytic encounter brings a range of cultural and social factors into play.

Physical Access to Counselling

Whilst the papers in this issue have focused in different ways on questions of difference, power relations, counselling and therapy primarily in relation to questions of identity, in this last section I wish to return to the most practical question of access to therapy in order to show that even here access is never just a social matter. Who comes into buildings and how they get in gives important messages about social inclusion.

The reason I am returning to this greatly rehearsed subject is because so often, when working as employees or in private practice, there is an abdication of responsibility for environments. Planners may be unintentionally disablist when designing and adapting buildings to make them accessible to all. Users of buildings tend only to notice barriers when they are personally affected by them. Van Rooyan's paper on 'There's no such thing as a building' (echoing Winnicotts phrase, there's no such thing as a baby) showed that infantilising care is needed when environment is hostile. In his inclusive architecture he aims to make buildings readable to all potential users.

> Very complex buildings usually attempt to overcome their labyrinthine chaos with hundreds of written signs... by paying attention to the co-ordination of all the disparate elements, including shape, volume, transparency, incident, texture, colour, lighting, acoustics, and fittings, we can make 'readable' which people find comfortable and memorable in use.

The psychoanalyst Winnicott argued what a baby needs is a 'facilitating environment', one that is attuned to its needs protecting it from too much knowledge of its own vulnerability. This idea can be applied to the physical (built) environment. He saw the primary carer as providing this facilitating environment. Human beings are dependent on a facilitating environment to grow, develop and learn.

It is crucial that clinics offering therapy are both accessible and welcoming to everyone. This does not just mean that it is wheelchair accessible, has hearing loops, good signage and staff who have appropriate disability equality training. It also means that any adaptations are aesthetically in tune with the building. As Napolitano puts it so well,

> I wasn't at all happy with the idea that getting my share of what goes on in those buildings should inevitably produces an aesthetic blot on the cityscape... Being able to use the environment is about more than being able to 'get about'. At a deeper level it is about a sense of belonging (1996: 34-35).

Therapists (particularly those with a psychoanalytic orientation) have often been accused of being 'precious' and failing to become involved in social and institutional matters. Child psychotherapists in the UK have been treated with some suspicion, but other professionals such as social workers and psychologists, because they are so focused on protecting their young clients confidentiality, can be seen as failing to make a contribution to professional team work. Similarly, the intensity of therapeutic work leaves practitioners with little energy for engaging with issues outside the consulting room. The matter is made worse because so many therapists work privately. The isolated, primarily dyadic nature of their work makes it harder for them to take of broad social and cultural concerns. For this reason, developing an inclusive disability practice needs to be a central consideration early on in training. Clinical examples need to draw upon clients from a wide range of social backgrounds and training should focus not just on what happens between client and therapist in the room, but how the client gets to the room and how the social world treats them. Therapists cannot avoid engagement with the context in which they work or the wider social context if they are to develop an inclusive practice.

Conclusion

This special issue and this paper have attempted to examine some highly charged questions about difference, power, counselling and therapy and social inclusion. It aims to contribute to the debate within Disability Studies around the relationship between disabled people and rehabilitation and therapeutic professionals. However, perhaps more importantly, it attempts to encourage thinking about disability amongst 'mainstream' practitioners who currently have few disabled clients and fail to make their practice accessible to all.

Endnote

1. The list of such accounts is enormous, but ones that are particularly powerful include Hockenberry, 1996; Finger, 1991; Cohen, 1995; Williams, 1992.

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