The therapeutic task here is to raise awareness of the role of physical and emotional courage and of the possibility of challenging authority and exploring relationships and sexuality.

LEARNING POINTS

- Regardless of the client's chronological age he or she may still be struggling with unfinished tasks of adolescence, which can cause confusion about identity and self-image.
- The four tasks of adolescence, as described by Blos (1967), offer the therapist a useful developmental framework for facilitating the maturation process.
- People who were born with an impairment may never have had the necessary encouragement to grow up and reach adulthood, while people who have acquired a disability later in life may find themselves regressing into adolescence because they have not been prepared for life as a disabled adult.

Summary

This chapter has considered the ideas that directly or indirectly underpin clinical practice with people affected by disability. The medical model concentrates on the possibility of change, while the social model addresses equality and inclusion by viewing disability as a social construct. The preferred psychoanalytical approach is the object relations construct of disability, or relational model, as presented by Klein, Fairbairn Winnicott and Mahler. Its emphasis on early childhood interactions between children and their primary caregivers offers a paradigm for understanding the emotional development of disabled people. The relational model is based on the concept of transition. It takes the conflicts, difficulties and achievements that characterise the tasks of adolescence as a useful organisational structure for understanding disability. Autonomy, identity and separation are recognised as the main elements of the ongoing transitional process.

Therapists who work with people affected by disability may be encouraged by the idea that the personal and emotional effects of disability and environmental impingements can be worked through if the therapeutic relationship is well held and contained.

3

DISABILITY AND THE PRACTICE OF PSYCHOTHERAPY

This chapter explores the therapist's task of managing the therapeutic relationship. The opening vignette draws attention to issues relating to the initial contact and assessment, and examines aspects of this that have particular relevance for disabled people. Respect by the therapist for the client is a necessary precondition for the formation of a positive relationship and enhancement of the client's autonomy. The vignettes illustrate the complexity of working with a client whose physical dependency necessitates a high level of care and medical intervention. The role of the therapist as the client's ally will be compared and contrasted with that of other carers and health professionals.

The First Contact

The duty counsellor's phone rang. On the other end of the line a woman asked 'Do you do counselling for disabled people? I need to arrange therapy for my daughter.' Without waiting for a reply she spoke about the family's recent return from Switzerland to England and her daughter's rare and complicated medical condition (disonomia). The duty counsellor asked how old the daughter was in order to ascertain whether she was still under parental guardianship. Lynn was 29 years old so the counsellor explained that the first step in the referral procedure was for the prospective client to contact the service in person.

The next day Lynn phoned the agency to ask for an appointment, but when it came to arranging the time and venue she handed the phone over to her mother. when Lynn arrived for her first appointment she was in a wheelchair and her mother was pushing her. The therapist opened the door for Lynn to enter, where upon the mother expectantly asked the therapist, 'Do you want me to come in?' Rather then responding to the mother the therapist turned to Lynn and said 'Lynn,

this is your therapy time, you can decide how you want to use it.' Before Lynn had time to reply her mother spoke about Lynn's medical condition and its manifestations, to which the therapist said, 'I believe Lynn will tell me as much as she wants me to know.' Lynn then said 'I will stay on my own.' She got out of the wheelchair and wheeled it into the consulting room. The wheelchair was never again brought to therapy.

Once in the room, Lynn said 'Sometimes I feel very upset, but I can't be upset at home, my parents don't like it. My mother is very worried about me; she would not allow me to dye my hair like my cousin does. She says it is too dangerous; it may hurt my eyes.' After a deep sigh she added, 'What's the point of it all, if I can't do anything I like?'

The above is a short example of the process that culminates in the first contact between client and therapist. But picking up the phone to ask for therapy is not the beginning of the process, so what is the starting point? What leads to the first contact? What motivates people to seek therapy? Individual clients will have a different answer to these questions, but in each case the process begins long before the first session.

The reason for contacting a therapist usually falls into one of two categories: the individual is experiencing internal or external difficulties that are more than she or he can cope with alone; or the individual is seeking personal growth and a better insight into her or his mental and emotional processes, often as a part of a training programme. Ultimately, however, the two are not mutually exclusive: people who enter therapy for a specific problem may also gain insight into their internal processes beyond that problem, while students who enter therapy only to fulfil a training requirement may uncover hidden problems.

LEARNING POINTS

- The way in which the first contact is managed becomes an integral part of the therapeutic relationship.
- A disabled person may experience more difficulty with and be more hesitatant about seeking therapy.

Assessment

Psychotherapists differ in respect of theory and practice. There currently exist hundreds of approaches to counselling and psychotherapy, all of which are aimed at finding a useful and workable way of

alleviating suffering and bringing about a better quality of life. Some of these approaches focus on specific client groups. The rationale for dividing clients into groups varies a great deal, ranging from the need of professionals to categories to the wish of specific interest groups to assert their group identity. Disabled people may find themselves categorised both by professionals and by movements and organisations of disabled people. Throughout this book the term 'disabled people' is applied to people with some kind of impairment, but this might be all they have in common as in other respects they represent the full cross-section of society.

Assessment is widely used to categorise people, but what is the rationale for using it in psychotherapy? Moreover what do we mean by 'assessment'? According to *The Shorter Oxford English Dictionary* it is 'Evaluation, estimation, an estimate of worth'. The notion of assessment in psychotherapy covers a range of acknowledged and unacknowledged purposes and intentions. It is not always clear whose needs are being served by the assessment: is it aimed at finding out what is best for the client, or is it a defence mechanism by which therapists and organisations protect themselves from the suffering that clients bring to their doorstep?

In psychotherapy 'assessment' is akin to the medical diagnostic process. But unlike medical diagnosis it is not always clear what is being assessed. Is it the client's mental health, background or ability to participate in a therapeutic relationship? If all three, in which order or combination? How can, some or all of these aspects of the client, which are not clearly defined or agreed upon, be assessed in a single session?

Another issue that requires further investigation stems from the ongoing debate on the indicators and knowledge base that inform psychotherapeutic diagnosis: is it possible to integrate intuition, information and systematic method into a reliable and useful assessment process?

There are several schools of thought on the purpose of assessment and the way to conduct it, the latter ranging from an interrogative exercise where the assessor asks a fixed set of questions, to what amounts to a mini therapeutic session. Hinshelwood (1991) proposes a 'trial interpretation', where the assessor conducts the interview as a mini session. When the preceding contacts are viewed as part of the therapeutic process, the assessment will reflect that process and will indeed be like a mini session. A reliable way of finding out whether people are able and willing to make use of the therapist's skills and expertise is to give them a sample of it rather then bombarding them with questions. In this method the assessor starts with a question such as 'What brings you

here?', 'Where would you like to start?' or 'How can I be of help?', but from then on he or she listens and interprets as in any other session.

Some therapists feel that transference interpretations, in which the therapist comments on the client's perception of the therapist and relates this to early relationships, should be avoided during the assessment session, especially if the assessor intends to refer the client to another therapist. This view is based on the assumption that transference is unique to the therapeutic encounter.

As indicated, transference is the transfer to the therapist from the client of emotions previously directed at another person or thing. When human beings engage with other people the presence of the latter triggers conscious or unconscious associations, which then affect the way in which they are perceived. Although we do not call it transference in everyday interactions, the choice of what to communicate contains a comment on the other, as well as the actual information.

Let us look at Lynn's comment after her mother had reluctantly left the therapy room: 'Sometime I feel very upset'. At that point it would have been helpful and appropriate for the therapist to offer an interpretation that acknowledged Lynn's perception of the therapist as upsetting the mother as well as sharing Lynn's feelings about her parents. Such an interpretation would have offered Lynn a taste of what the psychotherapeutic relationship was about, an experience that would enable her to tell whether this was what she was looking for. As for the therapist, Lynn's reaction to the interpretation would have indicated whether she was ready to receive this form of therapy.

As well as assessing the client's ability to engage in a therapeutic relationship, the assessment procedure could form part of a defence mechanism in which the assessor serves as a gatekeeper to protect the interests of the system rather then those of the client. Thinking of the assessment process as a diagnosis brings with it the sense of certainty that is attached to some aspects of medicine, where clearly defined diagnostic tools are used and the outcome is seen as predictable. This assumption of certainty and the power to cure help to reduce the anxiety triggered by the uncertainty of facing a new and unknown client.

A different concept of assessment is of a natural process that commences whenever two people meet for the first time, and is not limited to the one or more sessions allocated to the task. It is an ongoing, two-way process in which two strangers, in our case the client and the therapist/assessor, assess each other. In his or her mind the client formulates a view of the organisation and the therapist, but may have been anticipating what it will be like to engage in therapy long before

the first session/assessment. The client's premeeting assessment is based on a combination of written information, phone calls and perhaps some discussion with the referring agent. The assessor may also have started the process by communicating with or about the client, for example by phone, a written referral or a letter.

LEARNING POINTS

- The purposes and practice of assessments are varied and changeable.
- To avoid misuse of assessments, the usefulness and appropriateness of the assessment method should be subject to regular evaluation.
- The process of assessment and evaluation continue throughout the therapeutic relationship.

Managing the First Session

The wish to help

When the therapist first saw Lynn she felt a desire to take care of Lynn and make her better, to take away this awful condition that had stunted her growth and left her so fragile and vulnerable. The therapist's inability to bring about a physical change caused frustration and a sense of helplessness. Becoming aware of and acknowledging this not only prevented mismanagement of the relationship, but also gave the therapist a glimpse into Lynn's on going experiences and created a common ground for understanding her predicament Therapists, like other care workers, experience an internal struggle between the omnipotent wish to make a difference by appearing strong and able and the awareness that acknowledging one's own limitations and frustrations is a prerequisite for empathy and understanding. When therapists are able to let go of the fantasy of being a saviour they arrive at a more realistic perception. They become aware that their task is not to change or improve their clients' physical condition, but to participate in a mutual process in which the clients will be helped to develop their autonomy. By letting go of the fantasy of control the therapists may find themselves confronted not only by their clients' helplessness and vulnerability but also by their own. The discomfort caused by close proximity to the fragility of human existence is probably the main reason why many therapists refrain from working with disabled people.

Third-party involvement

Because disabled people are sometimes perceived as incomplete there is a tendency to fill in the missing parts by bringing in elements external to the therapeutic dyad. These elements are referred to as 'third party'.

Let us look again at the initial contact with Lynn. The first call was made by the mother, who presumably took charge because she did not believe that her daughter was capable of doing so. She also informed the duty counsellor that Lynn's medical condition was the reason, why she needed counselling. At that point confusion could have arisen as to who was actually seeking help. It is not unusual for a referral to be made by a relative who is unconsciously seeking counselling for him- or herself but is not yet ready to admit it. Challenging Lynn's mother on her motive, would not have been productive and could have resulted in unnecessary tension and heightened defences. Instead the counsellor, who had been trained to deal with confused and worried relatives, simply explained the referral procedure, which in order to promote client autonomy usually requires the prospective client to contact the service directly.

Another approach would have been to offer family therapy, in which the family would be treated as a unit and its dynamics and interactions explored and explained. The reason for not offering family therapy when the original request is for individual therapy is that a disabled person often needs help with issues such as impaired autonomy and a blurred sense of self. For disabled people, natural separation from parental figures is often delayed due to the complexity of the practical and emotional issues involved. Their need to experience a private space of their own is often best addressed initially through individual therapy. Then, when appropriate, family therapy could be suggested as a follow-up.

When Lynn eventually did contact the service herself she was not ready to take charge and quickly handed over the phone and control to her mother. This was the first evidence of her inner conflict between autonomy and dependency. Therapists who become aware of such conflicts, either directly when taking the initial call or indirectly through the duty counsellor, organise their thinking around this conflict. When Lynn and her mother arrived at the counselling centre the mother, still in control, tried to push both Lynn and herself, physically and symbolically, into the first session. This was a difficult moment for the therapist, who was meeting mother and daughter for the first time and was unsure of the dynamics between them.

It is clear that mutual dependency played a major part in this mother–daughter–therapist triad. When the mother asked 'Do you want me to come in?' the therapist felt as if she was walking on a tightrope, with Lynn's autonomy as the client at one end and the mother's position as the principal carer at the other. However as Lynn was identified both by her mother and by herself as the client it was clear that initially a dyad rather than a triad needed to be established.

The options open to the therapist in respect of managing the first meeting were as follows:

- To let the mother in and approach the therapeutic work from a systemic, family perspective.
- To say to the mother something along the lines of 'I am sorry, but only Lynn can come into the room.'
- To put Lynn in charge of the decision.

We shall look at the advantages and disadvantages of each of these options in turn.

First, having both Lynn and her mother in the room would have given the therapist an opportunity to observe the dynamics of the mother–daughter relationship, which might have offered some understanding of Lynn's everyday life. By agreeing to the mother's request the therapist would have promoted a positive relationship with her, Lynn's main carer, and obtained information about Lynn that might have lessened the anxiety of working with an unknown client. As for the mother, she would have received a degree of counselling by proxy. Any therapist who chose to include the mother would have needed to think long and hard about how and why a request for individual therapy had turned into family work. Lynn's space, time and relationships were already controlled for her, and going along with the mother's desire to be present would have meant that Lynn's need to gain control and develop her autonomy would have been pushed to the side.

Second, the therapist's clear assertion that only Lynn could enter the room could have made Lynn feel that at long last she had an ally, a professional who was on her side rather then her mother's. It would also have made clear to the mother and Lynn that the therapeutic frame was strong and non-negotiable, and therefore reliable. On the other hand, if the therapist had made the decision for Lynn she might have perpetuated Lynn's dependency by exchanging a controlling mother for a controlling therapist.

Third, in the end the therapist decided to take a calculated risk and give the decision-making power to Lynn. The risk was related to the

fact that this was the first meeting and Lynn would be the therapist's sole source of information. Furthermore, she did not know how Lynn would respond to the power and trust invested in her, and how it would affect her relationship with her mother.

When the therapist told Lynn that this was her therapy time and she could decide how to use it, the mother, obviously feeling somewhat excluded, reacted immediately by giving instructions relating to Lynn's medical condition – she used her knowledge of and involvement with Lynn's condition to assert her own importance. The therapist, in keeping with her decision to foster autonomy in Lynn, turned to the mother and said, 'I believe Lynn will tell me as much as she wants me to know.' This comment served to establish the basis of the therapeutic relationship:

- From then on only Lynn and the therapist would take part in the therapeutic relationship; there would be no third party to cause confusion.
- Lynn was an adult and that was how she would be related to in the therapy.
- The therapy would focus on Lynn and not on her medical condition. The therapist did not need to know all the details of it.

Hence the therapist's efforts were directed at establishing Lynn's status as an adult and offering Lynn a space in which to exercise her autonomy. Her response 'I will stay on my own' indicated that she was willing to try to let go of her dependency on her mother. Her getting out of the wheelchair can be interpreted as 'I need the support of the wheelchair at times, but I want to be the one who controls it.' Lynn's first comment in the session – 'Sometimes I feel very upset' – was possibly triggered by the difficulty of having to choose between mother and therapist, a little like a child having to let go of her mother on the first day of school.

Despite the pain of separation, Lynn desperately wanted to be like any other young woman, which she indicated by her expressed wish to be allowed to dye her hair, as her cousin had done. She had asked for help because her attempt to become an autonomous adult had been thwarted by parental anxiety and over-care. Although she knew that at times her condition could threaten her life, it is important to note that the first issue she raised was not to do with her disability or medical condition but with difficulties in her relationship with her parents, particularly her mother's anxiety.

LEARNING POINTS

- A clearly thought-out practice policy accompanied by well-structured procedures offer a supportive frame for both therapist and client.
- When a disabled person requests individual therapy it is important to respect this wish, and to overcome the temptation to introduce others into the therapeutic relationship.

External information as an aspect of the third party

Why did the therapist dismiss the mother's offer to provide medical information? Should she have asked for Lynn's medical records so that she could learn more about her new client? Let us look at the possible advantages and disadvantages of obtaining medical information.

A positive aspect of medical information is that therapists' fantasies about a client's condition, its cause and its prognosis can be minimised in the light of scientific facts. For example a client with a severe skin disorder may trigger an image of leprosy and fear of contamination. Such associations are not conducive to the therapeutic relationship. With some conditions, such as epilepsy, therapists need to know how to act when the client has seizure. In general, once therapists have been told by the client about her or his medical condition, and are then able to relate to the client's subjective experiences, they may seek further information and understanding of that condition through further reading. Information on the condition as such is different from information on the client.

On the other hand medical information can prove detrimental to the therapeutic relationship. For example, when a therapist is informed about a client's medical condition before meeting the client it is highly likely that the therapist's perception of the client's concerns will be distorted (see Chapter 5). Also, as mentioned above, possession of a description of the medical condition could trigger an unconscious fear of contamination, pain and death, which might cause the therapist, especially if this is her or his first disabled client, to defend against this fear by relating to the client as a 'case' rather than a fellow human being.

Any information on the client that is obtained from someone other then the client means introducing a third party into the relationship, and might divert the therapist's attention away from the client's concern towards the concerns of those who supply the information. Clients who realise that their therapist is using other sources of information about

them may find it difficult to develop trust in the therapist, who could be perceived as going behind their back. Although it is difficult at times, therapists have to trust that their clients will tell them as much as they need to know. The information is not always straightforward, and may sometimes come in disguise, as happened in the following vignette.

Nine-year-old Gill's speech and gait were affected by cerebral palsy, and she had recently had several mild convulsive fits. Gill had been in therapy with me for nearly two years. One day she took a piece of card from her box, balanced it carefully on my head and said 'Stay still, relax.' She added: 'It will take only twenty minutes.' She than proceeded to put toys, pencils and more pieces of card on my head, all the while issuing instructions. I was somewhat nonplussed ...

What was it all about, what was she trying to tell me? However after a while it all fell into place. Through this game Gill was telling me what had happened to her at the hospital when the neurologist had been trying to find the cause of her fits. In this 'role play' Gill was the doctor and I became the patient. She was trying to communicate her feeling of puzzlement, of wondering what was going on. Taking on the role of a medical person was an attempt to understand the aspects of her experience that had not made sense to her at the time.

If Gill's mother had told me about this procedure beforehand I would not have gone through the wondering, not-knowing phase and Gill would have been denied the opportunity to share her puzzlement and struggle with the unknown. Role-play with children, like acting out with adults, is a form of 'communication by impact' that allows the therapist a glimpse of the client's world. The role reversal helped Gill to work through the experience of being subjected to the medical procedures, and of being just as out of control during the tests as she was during her fits. Because of her age Gill did not have access to information on the tests and therefore needed her therapist to share her fears and the experience of 'un-knowing'.

Although health professionals and their patients share the common aim of improving the health of the patient, conflicts can arise over certain medical procedures. For example procedure may improve a patient's physical health while at the same time reducing his or her overall quality of life. Furthermore some medical professionals overlook issues such as the patients' dignity and their ability to withstand pain, while patients do not always understand the reasons for their actions and therefore find it difficult to trust them.

Kate had muscular dystrophy, which affected her ability to move her arms. To slow down the process of muscle wastage it was important to keep her arms moving, so the physiotherapist instructed Kate's

helpers not to assist her at meal times as feeding herself would provide good exercise for her arm muscles. Every time Kate's favourite meal – freshly fried fish and chips – was put in front of her she could see it and smell it, but by the time she managed to get it to her mouth it was cold and tasteless so she was never able to enjoy it. Furthermore the arduous and exhausting ordeal made her too tired to enjoy any other activity. Why was it not left to Kate to decide what was more important, after all she was the one who had to endure the consequences?

A psychotherapist working in an environment such as a hospital can be tempted to fall in with the medical team as this may feel safer and more comfortable than maintaining a separate position. But clients who perceive the therapist as part of the team, as 'yet another medic', may not be able to view the therapist as an ally and lose the opportunity for a relationship that is influenced by no perspectives other than their own.

Let us look again at Lynn's first words to her therapist: 'Sometimes I feel very upset, but I can't be upset at home, my parents don't like it. My mother is very worried about me; she would not allow me to dye my hair, like my cousin does. She says it is too dangerous; it may hurt my eyes.' On the surface Lynn is sharing with her therapist an aspect of her life at home, but in order to improve our understanding of her communication we need to ask why she chose this particular story. In this narrative Lynn paint's a picture of caring parents whose concern about her medical condition renders them unable to relate to her as a young woman – they can only see her illness. Perhaps one of the reasons for her unconscious choice of this narrative as her first communication was to tell her therapist that there were enough people worrying about her medical condition and she did not need the therapist to become one of them. What she needed was an ally who would not succumb to the anxiety provoked by her physical condition and would relate to her as a person. In time, as trust developed, Lynn came to speak to the therapist about her experience of and feelings about her condition.

Autonomy and external information

The provision and receipt of care can confuse self-perception and self-image because there is a distortion of the balance of power. In the patient – carer relationship the patient, due to his or her medical condition, has to hand over responsibility to the carer. Such a relationship is reminiscent of the early mother – baby relationship, where the mother has absolute responsibility for the care of her baby. A competent

mother who is not too anxious can derive a great deal of satisfaction from having absolute power over another human being, and when a patient is in need of total care the same could be said of the competent carer. It is healthy and positive for the carer to derive satisfaction from the demanding task of providing such care. However the challenge is to let go of this power when the patient's need for total care subsides.

The intensity required to provide total care can lead carers to treat their patients as annexes of themselves; rather than as a separate entities. Disabled people who experience long periods of total care have to learn to tolerate a state of fusion with their carers, and may even long for it. The regressive experience of giving up responsibility can lead to a 'Peter Pan syndrome', whereby patients who have lost trust in their own body try to avoid regaining adult responsibility: in order to remain in the regressive state of total care.

When a client shows a tendency towards the Peter Pan syndrome the therapist's role is to identify and acknowledge the fear and exhaustion being experienced by the client. The client's need to retreat from the harsh reality of life should be respected by the therapist, while facilitating the process of restoring the client's autonomy. The first step in this process is to establish the separateness of each individual by defining the boundaries between self and others. One way of doing this is to insist that any information on an individual belongs to that individual and can be shared with others only at the individual's discretion. Therapists who follow this rule build up a relationship based on respect. Therefore the way in which medical or any other information on a client is to be managed must be carefully considered. Unless such information is essential to the therapy the therapist should refrain from seeking or accepting it prior to seeing the client. This will also help to prevent the therapist's perception of the client from becoming contaminated. The drawback of expecting clients to be the sole source of information is that they have to repeat their story yet again. However, most people are grateful for the opportunity to do so, especially if they can do it at their own pace. People do not often come across a listener who is genuinely trying to understand their unique experience, rather than comparing it with that of others in order to diagnose and categorise.

LEARNING POINT

- When psychotherapists minimise their exposure to their clients' medical information they enhance their ability to understand and work with the clients' own perceptions and experiences.

Managing the Therapeutic Frame

Home visits

The voice on the answerphone said 'This is Terry, social worker from team B. My client, Mrs Soyer, needs counselling. She is in her early seventies, very fragile and frightened.' The therapist returned the call and explained to Terry that standard procedures covered earlier. Mrs Soyer herself had to call the counselling centre to make an initial appointment. Terry was surprised: 'Can't you just tell me when you intend to go to see her and I'll arrange it.' The therapist realised that there was a discrepancy between the concept of counselling held by Terry, the well-meaning social worker, and the counselling she was there to provide. In the discussion that followed Terry explained that Mrs Soyer lived in a first-floor flat without a lift and that she had difficulty negotiating the stairs. She was also a little paranoid and very suspicious of strange people. Therefore it would be best if he went with the therapist to see Mrs Soyer in her own home, as she knew and trusted him.

Should the therapist have gone along with Terry's idea? Visiting the client at home would have been an opportunity to ascertain the extent of her physical limitations and emotional distress as well as offering a glimpse of her lifestyle and other pertinent factors. It would also have pleased the social worker. However the therapist explained to Terry that the time and place of the meeting had to be negotiated between herself and Mrs Soyer in accordance with the counselling service's policy, in which home visits were a rare exception. Terry reluctantly agreed to give Mrs Soyer the phone number, but warned that this would not work. Nonetheless Mrs Soyer did call, and a few days later went to see the therapist in the consultation room. She had also managed to arrange her own transport.

In the first session Mrs Soyer talked about certain doctors who had not listened properly to her description of her complaint, misdiagnosed her and administered an unnecessary treatment that had caused her a problem with balancing. In effect she was expressing distrust in the professionals' ability to understand her needs and respond to them appropriately. She perceived her disability as the result of the professionals' incompetence. Listening to all this the therapist asked herself the same questions that I had asked myself during my encounter with Gill. 'What is this all about?' and 'What is the client saying to me?' Before attempting to answer these questions we need to map out the context in which this first session took place.

- The idea to seek counselling had come from the social worker. Therefore counselling was perceived by the client as an element of social work provision.
- The social worker had promised to arrange it for her.
- The therapist had not cooperated with the social worker.

The therapist tried to organise her thinking around these facts and began to formulate an interpretation based on the mother–child relationship:

- The social worker and the therapist represented the parental couple getting together in order to take care of the client/child.
- The social worker represented an overprotective parental figure who offered help without considering or encouraging the clients real ability.
- There was a split in the parental couple and the client received a different message from each party. The social worker's message was 'You are weak, unable to go out; you need me to look after you', while the therapist's message was 'You are an adult and I will relate to you as such, unless you ask to be treated differently.'

The therapist's belief in Mrs Soyer's ability encouraged the latter to exercise her autonomy. However the conflict between the social worker and the therapist made her uneasy. Doctors, social workers and therapists were all professionals who were there to help her. Yet in her experience they did not always know what they were doing and could actually cause harm. Her first comment was an unconscious plea to the therapist to listen to her and not to misdiagnose her as the doctor and social worker had done. Another interpretation is that the therapist had misdiagnosed the client's ability and made a heavy demand on her by relating to her as an autonomous adult. The therapeutic relationship that followed this initial exchange indicates that the therapist's diagnosis was right – Mrs Soyer kept her regular counselling appointments for two years and arranged her own transport without the social worker's help.

'Why don't you see people in their own home?' This question has been put to me many times, mostly by social workers and other health and care professionals, and rarely by clients seeking the service. The issue of home visits is a delicate one and requires sensitive judgement. For some of those who seek professional help it is very difficult or even impossible to leave their home to meet in a neutral place, so home visits are the only way to receive necessary services, including psychotherapy. These people, however, represent only a small minority of those who are reluctant to leave their home. The majority, for variety

of reasons, are unwilling to make the effort to go out but are well able to do so, although some support, night be needed. The difficult task for a professional helper is to differentiate between the two groups.

There is an innate conflict between autonomy and dependency. The wish to help and be needed, which often underlies people's decision to enter a choice caring profession, can at times promote dependency when the declared aim is to facilitate autonomy and self-reliance.

Imagine a scenario in which the therapist goes along with the social worker to see the client at home. A triad is created in which the social worker is in the paternal role. The therapist might then be perceived by the client as someone who cannot manage on his or her own. Being offered a 'weak' therapist could reinforce the client's sense of helplessness and diminished autonomy.

Another aspect of home visits is lack of neutrality. The home is the client's private space. The client may initially be keen for the therapist to enter and share this space, but as in most relationships there are likely to be times when the client needs to express his or her anger. For example when a therapist takes a break, some clients communicate their sense of abandonment and rejection by cancelling a session before or after a scheduled break. Clients who find the therapist's absence very painful may not even call to cancel as they need the therapist to experience anxiety and frustration. This is impossible when therapy takes place at the client's home as the only options are to call and cancel the session, to be out, or not to answer the door, none of which deliver the same emotional message as letting the therapist wait, not knowing whether the client will come. Other factors that can erode the privacy and neutrality of the therapeutic space include other people sharing the home, unexpected callers and telephone calls.

Therapy in the client's own home is a compromise. The home contains a range of memories and experiences that may need to be addressed from a distance. Whenever possible the therapist should offer clients uncompromised therapy. However if a client is unable to get to the consulting room the therapist may make an exception, but this has to be considered very carefully as home visits can create confusion and undermine the therapeutic relationship.

LEARNING POINTS

- Therapists who work with disabled people may find themselves under pressure to offer therapy at a client's homes because of mobility or health problems.

- Most clients respond positively to therapy in a neutral environment, and can be encouraged to overcome the problem of getting there.
- Conducting therapy in a place that is not neutral, such as the client's home, is a compromise that should be avoided whenever possible.

Entering the consulting room

Like most of the issues discussed in this chapter, the management of boundaries is not peculiar to work with disabled people. However the existences of a disability and some habitual reactions can confuse the way in which responsibility is shared between client and therapist in the therapeutic relationship.

Let us look at how clients enter the consulting room. Ideally the client should arrive at the appointed time and the therapist should open the door. But when clients first have to wait in a waiting area, who shows them to the consulting room? Counsellors and psychotherapists working in the NHS or independent agencies are often expected to come out of the consulting room and escort the client into the room. This routine is similar to the way in which doctors or their nurse usher in patients, but is it really appropriate for a client in a psychotherapeutic relationship?

There are some fundamental differences between the nature of doctors' work and that of therapists. Doctors mainly operate on the basis of one-off appointments, while therapists aim to develop a regular, ongoing relationship. Also, in the course of their work doctors have to respond to emergencies and individual consultations often take longer than expected. Therefore patients have to wait until the doctor is available. In psychotherapy the clients have a fixed time, so, having to wait for the therapist to invite them in indicates that this time is not under their control but is dependent on the therapist's discretion or generosity. Such an arrangement could feed the clients' helplessness and dependency and delay autonomy. If possible clients should be encouraged to knock on the therapist's door at the appointed time. Unless the security arrangements in the building or a physical impairment necessitate it, escorting clients should be avoided because of its infantilising nature.

Clients who need to be escorted

Ian, a successful journalist in his mid thirties, was paralysed as a result of a train collision. His wheelchair was not motorised and he needed a

carer to escort him to and from the therapy sessions. This arrangement put into question Ian's body boundaries. Had the wheelchair become an integral part of Ian, forming a single unit? And what about the carer? Had he or she been integrated into the entity called Ian? In general, if a wheelchair and carer are there to replace disfunctioning limbs, does this mean that they are perceived as part of the client's body? There is no absolute answer because each individual relates differently to his or her wheelchair and carer. At one end of the scale are those who view their wheelchair as part of their body self, at the other end are those who hate their wheelchair because it is a symbol of their dependency, and in the middle are those who see it just as a mechanical device that facilitates movement.

The therapist could become another element in this complex interplay of testing and reidentifying boundaries. When a client in a wheelchair is escorted the therapist needs to consider two additional issues: how to relate to the wheelchair, and how to relate to the escort.

The wheelchair

As a matter of course, it is the therapist's responsibility to arrange the consulting room furniture. The chairs should be close enough not to cause a sense of isolation, but sufficiently far apart to avoid the sense of suffocation that can result from close proximity. However clients in a wheelchair have the relative freedom to choose where to position themselves in the room, which can leave the therapist with a dilemma. Should they be left free to choose any position, or should they be guided to a position that the therapist believes to be conducive to therapy? What should the therapist do if a client positions him- or herself too near or too far away?

The question of whether to reposition the client is a delicate matter because a wheelchair is not just another piece of equipment. As discussed above, for some people it becomes part of their identity, even part of their body. Therefore the experience of being moved around in a wheelchair is comparable to a non-disabled person's experience of being pushed about.

One day Ian was wheeled by his escort into the consulting room and positioned so that the therapist could not close the door. The therapist said 'I will have to move you forward a bit so that I can close the door.' Ian did not respond immediately. Later on in the session he talked about old friends who were trying to keep in touch with him. He was unsure of their motives. Did they enjoy his company or did they wish to see him out of pity and charity? Ian was not only sharing his

doubts about his friendships, he was also telling the therapist that the experience of being wheeled by her had harmed his fragile sense of equality as a fellow human being.

The escort

When a client comes with an escort the therapist has to consider carefully how to relate to the escort. Lynn's mother was an example of a pushy escort, and it was clear to the therapist that the therapeutic space had to be protected from invasion. Paradoxically an overinvolved and seemingly strong escort can help to sharpen the therapist's awareness of the need to maintain the therapeutic boundaries and ensure the client's privacy and confidentiality. Such an escort also frees the therapist from the need to look after him or her, so she can fully engage herself in her client's needs without feeling mean or guilty about neglecting the escort. It was different when Ian and his escort were late for therapy one day after a very difficult journey in a winter storm. The therapist's impulse as host was to offer the escort a warm welcome and a cup of tea. This friendly human gesture might have made the therapist feel good about herself and comforted the escort, but how would it have affected the client?

Therapists who work with escorted clients have to re-examine the therapeutic construct and consider the escort as a third party. Unless the escort is the client's partner and both come for couple or family therapy, the therapist should keep the interaction with the escort to the very minimum. But because the escort is a fellow human being and not an inanimate object it can be difficult to ignore his or her needs. Ian's therapist had to remind herself that the purpose of the journey was Ian's session and therefore she should leave the escort to take care of himself. Looking after the escort's needs would have taken away one of the fundamental elements of the therapeutic relationship: that for the duration of the session the client has the therapist entirely to him- or herself. Even with careful consideration and thoughtful action, the fact that an escort is involved in the relationship has a direct impact on the therapy and has to be integrated into the therapist's thinking and interventions.

Some readers may not see the practical issues discussed in this chapter as the main concern of psychotherapy. Yet having to acknowledge the particular reality of disabled people heightens therapists' awareness of the significance of the setting as part of the therapeutic frame (Langs, 1988), and highlights the importance of holding and

containment (Winnicott, 1975b) as fundamental elements of the therapeutic process.

LEARNING POINTS

- The need to consider and protect clients' autonomy increases in inverse proportion to their degree of physical dependency.
- When a client's life is affected by physical constraints the significance of the therapy's practical and physical aspects increases.

IMPLICATIONS FOR THERAPISTS

Disability affects the therapeutic relationship in the following ways. Psychotherapy with people who are in physical as well as emotional distress can be a difficult and lonely experience. Unlike doctors and nurses, who have the opportunity to discharge their anxieties through action-oriented tasks, psychotherapists' task is to stay with distress and anxiety to enable clients to gain a better understanding of their predicament, and thereby to restore or achieve autonomy. Therapists working with people who are also under medical care may be consciously or unconsciously tempted to alleviate difficult emotions by busying themselves with medical issues.

Therapists who find themselves in close proximity to what seems like overwhelming human suffering sometimes develop distancing defence mechanisms. Distancing techniques aim either to objectify the other, for example by devising pseudoscientific, rigid assessment procedures, or to infantilise through a patronising attitude. Whatever the distancing method the usual outcome is lack of respect for the client's who are related to as though they are objects or a babies.

Working with disabled people adds a sense of urgency to the wish to help, which can cause considerable frustration as therapists recognise their limitations. A difficult task for therapists is to identify and monitor how differences in appearance and physical functioning affect the way they relate to disabled people. For example if a person's speech is unclear and garbled it might wrongly be assumed that the thought process behind it is also unclear and garbled. Disabled people are very sensitive to the attitudes prompted by the assumed link between physical disability and mental impairment.

Summary

This chapter has focused on the clinical practice of therapeutic work with disabled people. The emotional and practical difficulties raised by clients' disabilities have been addressed in terms of management of the therapeutic setting and relationships with other caregivers. The challenge of maintaining neutrality and privacy has been contrasted with the temptation to allow third-party involvement. The main theme has been the importance of maintaining clear and firm boundaries when developing and strengthening the autonomy of disabled people.