A PORTFOLIO OF ACADEMIC, THERAPEUTIC PRACTICE AND RESEARCH WORK INCLUDING AN INVESTIGATION OF DISABILITY DISCOURSES

By

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Any therapeutic work referred to in this portfolio has used pseudonyms and excluded any identifying features in order to maintain confidentiality.
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Prologue.

The viva I attended in order to assess this portfolio gave me an opportunity to reflect upon my overall development during the three years I spent on the doctorate of psychotherapeutic and counselling psychology and allowed me to view my academic work as a whole. This highlighted the fact that there had been a big shift in my thinking, moving from a more traditional understanding of psychological concepts, as an undergraduate towards a more critiquing stance in my postgraduate work. Although this may have been present in my thinking it was felt it was not apparent in my written work. Thus this prologue has been added in order to give the reader a sense of the epistemological shift that the course facilitated.

It was suggested in the viva that the early essays included in the academic dossier differed significantly from later work, in terms of their epistemological understanding. In particular the first essay which referred to the concept of identity in a concrete way, as if it were a tangible phenomenon that existed and could be studied. Although I was questioning the theory and considering how it perpetuates the construction of disability as negative, I had not developed my argument in order to consider what identity itself was and what epistemological assumptions such theories and concepts hold. This is in contrast to later on in the portfolio (primarily in the research dossier) where I perceive identity as a dynamic process, which is co-constructed within any social interaction. Although when starting the course I was interested in how meaning was ascribed to any given phenomenon and what gave it legitimacy, I had not encountered social constructionism as an academic theory. Therefore, encountering social constructionist ideas enabled me to see that the theories I had been evaluating, themselves were also based on certain assumptions about reality, power and knowledge. That is, they presumed that there was a truth that could be investigated and ultimately found. Such a positivist and empiricist stance made me feel uncomfortable, not only because it prescribed norms and rules, but also because it made claims about truth which has implications concerning power. That is to say, if you can claim that you can find and establish 'truths' then it is hard for others to argue with you. Thus, throughout the course I increasingly felt that there are no truths, but instead different meanings, which could be understood in
terms of historical and socio-cultural context. In my work I specifically related this to disability, but it applies more broadly to many of the theories and concepts taken for granted in psychology. This is of course a controversial stance, as it leaves psychologists with a less certain knowledge base. However, it seemed to open up new possibilities and create a way of reflecting on the old prejudices and problems of the psychological discipline. I felt it provided a way of moving forward as a therapeutic practitioner and an academic, as rather than seeking norms and truths, which seemed to be over-reductionist I could look for ways of understanding that were helpful to myself, clients and colleagues. This enabled phenomenological experiences and contextual issues to be considered, rather than only being able to look for understanding in terms of established theoretical assertions.

This also allowed me to develop my concept of diversity, which is a central aspect of my work. As an undergraduate I had already started to feel that within psychology people were being oppressed and over homogenised on the grounds of gender and racial diversity. The research component in this portfolio expanded this to include how disabled people are also oppressed by both psychological theory and society more broadly. I feel it is of great importance for me to promote the exploration of an understanding of diversity that moves away from dichotomies such as disabled/able or mental health/mental illness. I strive to move towards a way of conceptualising the human state on a spectrum. That is, we are all able and disabled to differing degrees, and we all experience differing degrees of mental health and illness. There are of course actual differences, mediated by our environment and our embodied states, but I believe such diversity is positive, reflecting the flexibility and creativity in the human condition. I feel the problems arise when in our attempt to make sense of such diversity we have categorised people (which some may argue is essential) and then attached meaning to such categories. However, more than this we have come to believe such categories really exist, and have compared any perceived diversity to an established norm. Thus although we may not be able to, or may not wish to abolish such categories I believe we need to start being aware that we have created them and then ascribed meaning to them. This may allow a fresh perspective, which values the diversity amongst us and may be the first step towards reducing stigma, prejudice and discrimination.
The ongoing challenge is how to balance such a stance with being a psychologist. The course gave me a good opportunity to consider this. That is, I was seeing the theory and assumptions of the psychological knowledge I had previously been taught in a new light, as 'a' way of understanding, not 'the' way of understanding. However, I chose to enter the institution of psychology and to do it in a recognised way by studying for a doctorate. Thus a challenge of the course, as with my future life and work will be to keep questioning assumptions and especially challenging discrimination whilst also being able to practise and develop as a psychologist.

There is a pragmatic element to this, in that I need to be able to function as part of an institution in order to work. However, I also feel it is important that I am able to draw upon what is helpful rather than dismissing the wealth of knowledge and understanding that is integral to psychology's history. Any institution whether it will be a university or health care system will provide certain rules to be abided by and will use certain discourses. Thus I need to find ways of blending my constructionist stance with being able to function congruently within potentially conflicting environments. As part of the course I found that writing up or analysing research, with in an academic institution, that had certain requirements meant that certain discourses were legitimised over others, and the 'silencing' I researched amongst disabled people, might well have been replicated in my own experiences. However, the institutions it is accountable to also restrict the course itself. Thus the process is pervasive. The first step towards challenging taken for granted assumptions is to make apparent what they are. Thus within any institution what is not being said or asked may need to be highlighted before new ways of speaking or asking can be developed.
Introduction to the Portfolio

This portfolio provides a summary of my academic, therapeutic and personal development throughout the three years spent studying for the Doctorate in Psychotherapeutic and Counselling Psychology. It contains pieces of work that highlight the issues that I found of particular interest, which in turn give an idea of how my therapeutic practise has developed. When writing this and reflecting on my experiences over the last three years, I feel that this course has enabled me to realise just how much more there is for me to go on and learn and to experience. Although I feel this course has given me a solid foundation with which to move forward, I also feel that it has only been the beginning of a process.

I came to Counselling Psychology almost by accident but feel retrospectively that this course will enable me to develop the career I was hoping for. I knew from leaving school that I wanted to work in a profession that allowed me to reflect on and address some of the societal problems I saw around me. This is what prompted me to undertake a B-Tech National Diploma in Social Care, intending to become a Social Worker. However, a combination of enjoying the Sociology and Psychology modules on the course and experiencing, first hand, through placements the tough deal social workers get, I decided that a degree in Psychology and Sociology was the way forward. On leaving University I still did not have a clear picture of what I wanted to do. I spent some time working, in Canada with people living on the streets, in a therapeutic children's home and in a variety of residential and drop in centres for adults with mental health issues. This taught me that I was not content simply containing and caring for people that I felt society wanted kept out of the way. Rather, I wanted to feel I was able to help such people by being with them and enabling them to make positive changes in their lives. It was then that I discovered the doctorate in Psychotherapeutic and Counselling Psychology. This seemed to provide an opportunity to be with people through therapeutic work, whilst enabling me to facilitate change, both on an individual level with the clients and on a more social level through research and critical analysis. Being able to question my own and others assumptions has always been important to me which may stem from growing up in a family that thrives on debate and discussion. This is further fuelled by my belief that
the society I am surrounded by and part of has some fundamental flaws. Counselling Psychology allows me to question traditional assumptions and theory, in order to consider its impact upon contemporary Psychology and society more generally.

The course provided me with an opportunity to learn how to address my concerns and questions through academic and professional training. Thus I feel this portfolio reflects many areas, as I wanted to explore as many different ideas as I could in the three years. I do not feel I have yet arrived at my destination as a Counselling Psychologist, but have been provided with many ideas regarding where I want to go.

The portfolio is divided into three sections, i.e. the academic dossier, the therapeutic practise dossier and the research dossier. I will give a brief overview of these three sections in order to consider how the different areas relate to my development over the last three years.

**The Academic Dossier**

This contains four essays, which were written over the three years of my course. The first of these is a critique of how traditional psychological theories of development (specifically Erikson's psychosocial theory of development) may perpetuate certain representations of disability. I felt it was important to include this essay because it indicates an important stage in my development. That is, it symbolises the shift I experienced when moving from undergraduate to postgraduate Psychology training, by demonstrating the move from ‘being expected to just learn theory’ to ‘being able to critique it’. Furthermore this essay marks the beginning of my interest in disability issues. Writing this essay introduced me to the idea that there was a choice about how to view disability and that assumptions embedded in Psychological theory may impact upon this. As I am disabled and registered blind this initiated my own journey of discovery regarding how I perceive my own disability, which led to a sustained research interest in this field.

The second essay I have included reflects upon the importance of the therapeutic frame. This reflects my belief that the pragmatics and professional boundaries relating
to therapeutic work are essential in order to ensure that good therapeutic work can take place. In addition, I think it may relate to my own reflections regarding how my sight, although not necessarily impeding my ability to be therapeutic did pose some challenges regarding the pragmatics of being a Counselling Psychologist. Although it is important for me to consider how any of my characteristics, including being partially blind may impact upon the therapeutic relationship, it is also important for me to consider the implications of being a non sighted person working in an environment designed for sighted people. Also whilst on placement as a college student I had recognised the importance of boundaries and this essay indicates how I consolidated my position on this during the course.

The third and fourth essays discuss transference and the use of relationship in cognitive behavioural therapy. These reflect how I developed an increasing emphasis on relationship throughout the course. I believe the experience of being in relationship is an essential consideration, not only in therapeutic work, but in life more generally. This is a focus that will remain central to my work as I go on to evolve as a practitioner. An account of how a relational focus evolved in my work can be seen in the clinical paper, included in the therapeutic practise dossier. The fourth essay relates to the increasing awareness of integrative ways of working that I developed throughout the three years (this is expanded on in the clinical paper), which I feel will be a central process in my future development. The integrating of cognitive behavioural and psychodynamic ideas, discussed in this essay, highlighted some of the potential challenges posed when working integratively. Furthermore, it highlighted the fact that I need to reflect on how I define specific concepts, such as transference, so as any integrative work remains defined and coherent.

**Therapeutic Practise Dossier**

As well as including the clinical paper mentioned above this dossier contains a summary of the placement work undertaken as part of this course. This summarises the therapeutic work I undertook over the three years. It describes the client centred, psychodynamic and cognitive behavioural/integrative approaches I used and the primary care, student counselling and specialist Psychology contexts that I worked in.
Although the written work, pertaining to the therapeutic work undertaken on placement, is available to the examiners of this portfolio, they are not included in order to maintain confidentiality. However, the combination of the description of the placement work I did as well as the clinical paper gives a flavour of the work I undertook.

**Research Dossier**

This contains the three pieces of research I undertook during the three years. These reflect my own personal journey through disability theory, and how I came to develop my own disabled identity, based on a social model of disability. This was facilitated by encountering a diversity of disability theory and research, but also by putting me in touch with other disabled people. That is, the exchanges I had with those people who participated in the research as well as with other disability researchers I encountered when joining a disability research discussion group. This resulted in my becoming a member of the British branch of the disability movement and becoming increasingly aware that disabled people are socially oppressed and excluded. Prior to this course I had been very aware of how people were discriminated against on the grounds of gender, sexuality or ethnicity but had never reflected on how my own cultural group, i.e. disabled people, were being oppressed. I think this new positive and empowered stance made it easier for me to reflect on how my own loss of sight impacted upon my therapeutic work, both practically and psychologically. That is, I was able to explore in my personnel therapy how being partially blind affected my life and my work without having to adopt the traditional perspective of disability as tragic and overwhelmingly negative.

The first piece of work in this dossier is a literature review. This enabled me to explore how contemporary psychological research dealt with the issue of disability and with disabled people. Simultaneously I was encountering the social model of disability, which differentiates physical impairment from disability. This approach asserts that the former is a physical state whilst the latter is the consequence of a society that constructs physical and social barriers for those who are physically diverse. I was disappointed to find that the psychological literature I reviewed
overwhelmingly adopted a medical model of impairment and that the research was
primarily undertaken by non-disabled professionals. I used a material discourse
perspective to consider what assumptions were embedded in the research. This led me
to conclude that such literature was perpetuating a traditional tragic and negative view
of impairment, sustaining the oppression of disabled people. This work also played an
important part in my own developing epistemological stance.

Thus the second piece of research in this dossier is qualitative and I strove to find the
voices of disabled people that I felt were missing in much of the psychological
research. Therefore, I asked disabled people about their sense of identity using
unstructured interviews. I then used a voice relational method to analyse the data in an
attempt to foreground the voices of the participants and consider what representations
or assumptions were inherent to our conversations. This hoped to make my presence
and influence on the research as transparent as possible.

The final piece of research continued this focus on how disabled people can talk about
themselves and their experiences of disability, this time using a quantitative method. I
struggled with this approach because of the assumptions I felt were embedded in it,
many of which I feel perpetuate negative representations of disability, overlooking
experiential and phenomenological knowledge and meaning. However, I felt I had to
take this opportunity to experience as much as I could, in order to help me know
where my future path lay. Although I still have reservations about quantitative
methods, I also feel the research raised some important questions about disability
studies and what is missing from it, as well as the implications of this for Counselling
Psychology.
ACADEMIC DOSSIER
How do traditional psychological theories, such as theories of identity development contribute to representations of disability?

Introduction

Identity may be said to be central to psychology as it defines the very unit that is studied. By its nature, the identity of an individual would seem to be a unique phenomena. However, traditional psychological theories have been formulated to define and explain identity and its development in a way that seeks generality. That is, traditional theorising within psychology has focused upon identifying and describing 'normal' patterns of development (Burman, 1994). Many of the traditional theories, such as Freud's (1964) theory of psychosexual development, Piaget's (1970) theory of cognitive development and Bowlby's (1969) theory of attachment have been based upon a staged, hierarchical, linear model of development, which are based on moving towards a more mature and desirable identity formation. Here, Erikson's (1968) psychosocial theory of development, which describes eight stages of development throughout the life cycle, will be used as an example of such traditional theorising. Although not all traditional theories are the same, Erikson's theory will be used to highlight some of the assumptions integral to much traditional theorising. It will be suggested that such assumptions serve to over-homogenise and that, rather than illuminating the inner workings of identity, the lack of diversity inherent to such perspectives serves to prescribe a norm. Furthermore, it will be argued that such models perpetuate a dichotomy of normal and abnormal, serving to define those who are not accounted for by the theory as abnormal or deviant. It will be considered how this may perpetuate the construction of disabled people as 'abnormal' (Burman, 1994). Finally, it will be considered what implications this may have for psychology as a discipline and specifically for Counselling Psychology.

Erikson's psychosocial theory of development

Traditional models of development, such as Erikson's (1968) psychosocial theory of development are still central to undergraduate teaching. This theory, along with other
traditional theories pertaining to development (e.g. Bowlby, 1969; Freud, 1964; Piaget, 1970) tend to be based on a staged process, presuming that identity development is linear and amenable to being clinically observed and defined. Such models are based upon hierarchical stages, which have a directional root, leading towards 'mature' development. Such theories require that each stage has to be achieved before successfully moving to the next. Thus, such theories, including Erikson's, postulate a model of normal development, which is desirable in order to become a successful adult.

Erikson (1968) suggests that a central task of adulthood is finding ones identity. He suggests that this happens through a process of transition from childhood morals to adult ethical values and describes eight stages which facilitate this; trust verses mistrust, autonomy verses shame/doubt, initiative verses guilt, industry verses inferiority, identity verses identity confusion, intimacy verses isolation, generativity verses stagnation and integrity verses despair (Erikson, 1968; p.64). He suggests that not until adolescence does a person acquire the necessary physiological, mental and social development to experience and pass through the crisis of identity, which will have significant consequences for later life. He suggests that in order that a person stays 'vital' they must experience and re-experience such crisis, with increasing competency.

Although Erikson accepts that a person can grow up without passing through these stages he asserts that this will lead to an 'abnormal or deviant personality'. There is little room for diversity in experience in such models, and thus Erikson's model implies that a child who does not pass through the prescribed stages will not develop a complete or adjusted self-concept. Although Erikson accepts that there are many definitions of healthy personality, and that competency is, in part, culturally defined, he still maintains that "based on the epigenesis principle [that] development has a proper order" (Erikson, 1968; p. 93). This seems to presume that everyone requires the same set of experiences in order to successfully develop a sense of identity. However, in addition to this, it means that those who are not able to follow such prescribed stages are perceived as being unable to achieve such successful development.
Social representations of disability

Some discussion regarding representations of disability is needed here, before going on to consider how Erikson's theory, and the traditional psychology it is indicative of, may contribute to such representations. Much work has been done, often in the field of medical sociology, to explore the historical construction of disability inherent to our western societies (Abberly, 1987; Barker, Wright, Meyerson and Gonick, 1953; Oliver, 1989; Shakespear, 1993). Such work suggests that disability has traditionally been conceptualised in medical terms (Barton, 1996), perceiving disability as based on physical impairment, located within the individual (Oliver, 1998). Thus, disabled people are seen to be the responsibility of the medical profession. Oliver (1998) asserts that this results in disabled people being seen as sick, tragic and in need of rehabilitation (French-Gilson and Depoy, 2000). Burman (1994) asserts that developmental psychology has contributed to the perception of disability as negative by measuring disabled people's mental attributes, classifying abilities and establishing 'norms'. Thus, by focusing on what was 'normal', it also defined what was 'abnormal'. Burman (1994) asserts that this perspective underlies psychological research and that, inherent to this, is a judgment regarding an individual's 'mental and moral qualities'. Negative representations of disability which portray it as abnormal and undesirable led to psychology treating disability as a tragedy to be grieved for (Asch and Rousso, 1985). It was seen as a loss that would provoke feelings of guilt and shame (Lindemann, 1981). Thus, it was presumed that such a trauma would result in the development of maladaptive personalities and behaviours (Hersen and Van Hasselt, 1990), and such representations became assimilated into society, becoming 'common sense' views of disability.

How theory contributes to social representations

It is suggested here that Erikson's model may perpetuate such negative representations, by constructing the idea of normal, desirable development and thus implying any divergence from this is undesirable, abnormal development. Thus, those who do not adhere to the prescribed root of development are perceived as deviant or
different. An example of this, specifically relating to disabled people, can be seen when considering the developmental stage Erikson calls the crisis of 'autonomy verses shame/doubt'. Erikson asserts that a child must increase their sense of mastery over the environment in order to resolve this crisis. He suggests that this is achieved through increased mastery over one's body, inclusive of mobility and language development. Erikson suggests that this stage is necessary in order for a child to develop a sense of purpose and ambition for future adult tasks (Erikson, 1968). The fact that this stage is defined in part by physical ability immediately makes it inappropriate as a measure of a disabled child's development. Furthermore, it marries physical development with psychological development, which Burman (1994) suggests has contributed to disabled people being judged as holistically less able. According to this theory a physically disabled child who is unable to explore the world freely would not gain the autonomy deemed necessary to develop through this stage, which Erikson suggests will lead to a person feeling a sense of shame. This reinforces the idea that disabled people feel shame due to their impairment (Lindemann, 1981).

Another stage that Erikson suggests is necessary as part of 'normal development' is the crisis of Initiative versus Guilt. He suggests that a school-age child acquires new skills which compliment their increased physical capabilities. It is suggested that a child needs a sense of industry in order to become "an eager and absorbed unit of a productive situation" (Erikson, 1982; p. 124). He asserts that this is essential in order to develop skills for later life and that if these are lacking a child will develop a feeling of inferiority, which will remain into adulthood. It is interesting that guilt is seen as resulting from an inability to negotiate this stage, as it is often perceived as accompanying shame in disabled people when adopting a traditional negative perspective of disability.

The stage referred to above provides an example of how a disabled person may be unable to achieve Erikson's prescribed path of development, due to societal restrictions rather than biological ones. That is, disabled people are likely to have less opportunity to develop the skills needed to participate in the workforce (Oliver, 1998). This may be due to being segregated into 'special' schools, which may promote
different (lower) expectations and goals to mainstream education (Oliver, 1996). Also, disabled people may be restricted due to social and physical barriers in education as well as the work place. This means that disabled people are less likely to have the opportunity to develop the skills Erikson refers to as necessary to resolve the crisis of Autonomy verses Guilt. However, as psychology traditionally takes an individualised stance to development and disability, rather than a social one, a failure to resolve this crisis may be pathologised as an individual psychological problem rather than an issue of social exclusion.

Furthermore, Kesler (1977) sees that overprotection is usually seen as the easiest option when working with disabled people. Similarly, Lindemann (1981) also suggests that fear of failing goals or shame means that disabled people are never allowed by their carers to practise, thus develop their independent skills. Thus, the assumption that disabled people are developmentally limited may come to be a self-fulfilling prophecy by resulting in being restricted through over-protection or excluded from learning about the ways of the world. Thus, others perceptions and behaviour toward disabled people may perpetuate the very assumptions and representations that led to such interactions in the first place.

Therefore, the concern raised here is that such traditional theories exclude diversity by virtue of their narrow focus, excluding subjective or diverse experiences. The underlying assumption that there is a pattern of 'normal' development which can be identified and defined and thus used as a framework with which professionals can view 'normality' serves to construct deviance. Here, it has been considered how this may apply to disabled people, but it may equally apply to anyone who does not fit such definitions of normal. Although Erikson's model has been focused upon it is suggested here that such presumptions of normality are inherent to much of traditional psychological theory (Burman, 1994; Shakespeare, 1996). Such traditional models, based on a positivist paradigm, underlie much undergraduate psychology teaching and thus reinforce to each new generation of psychologists the construction of normal as a desirable trait, and abnormal as something that needs to be rehabilitated and cured (Oliver, 1998). Such perspectives will be disseminated and become 'common sense'
knowledge, meaning negative representations of disability will become internalised by non-disabled and disabled people alike (Steele, 1992; Sutherland 1981).

**Implications for Counselling Psychology**

The theoretical stance adopted regarding how people develop, including what may contribute to maladaptive identity formation, has significance for psychologists, including therapeutic practitioners such as counselling psychologists (Lindemann, 1981). This is because a practitioner's perception of a disabled client will affect any therapeutic work. Parsons (1964) states that, traditionally, a disabled person is seen as needing to accept their 'sick role', positioning them as dependant. For many years Psychology has perceived a rejection of a traditional disabled role as denial (Wright, 1960) and that disabled people could not be helped therapeutically unless adopting the dominant perception of disability as tragic in order to grieve and move on (Asch and Rousso, 1985). Asch and Rousso (1985) and Lenny (1993) suggest that psychologists often perceive disabled people's problems as stemming from their physical impairments. Thus, therapeutic work undertaken with disabled people often overlooks any social explanations of disability or of disabled people's experiences as stemming from societal exclusion or oppression (Lenny, 1993; Oliver, 1996; Shakespear, 1996). This serves to perpetuate the idea that it is the person's maladaptive personality or individual problems that underlie any psychological issues. Furthermore, such assumptions may be perpetuated by the individualised physical emphasis inherent to Erikson's description of normal development.

In addition, individual therapists need to be aware of what representations of disability they encountered during their training, and how this may have effected their perceptions of and interactions with disabled people (Woolfe & Dryden, 1996). Davis (1961) suggests that social interactions with disabled people are coloured by either avoiding or centralising the disability. He suggests that false acceptance in interactions, masked by politeness, keeps disabled people on the periphery of social life. Lindemann (1981) postulates that people (including professionals) have trouble mixing positive and negative attitudes, thus physical impairment is associated with mental instability and learning difficulties. Chaudhuri (1999) suggests that disability
promotes anxiety in others, making them fearful of losing their own bodily integrity, as well as provoking anxiety regarding mortality. Therefore, psychological practitioners will need to be aware of what representations of disability they hold and how this may affect how they relate to disabled people.

Furthermore, research is needed in order to explore how disability has been historically constructed as negative and abnormal, so new developmental theories can be formulated which consider alternative perspectives of disability. This will need to include a consideration of what assumptions and representations may be inherent to the research process itself. Luborsky (1995) suggests that although clinical research claims to be value free, that in fact the researcher shapes the report of subjective experience by prescribing what responses can be given by participants. Thus, the clinician regulates acceptable forms for describing experience based on traditional ideas giving medical labels to personal experience. He argues that the de-contextualised nature of the information gathered has no true experiential aspect to it. This indicates how the language, and thus underlying values of the medical and psychological professions, more than failing to give disabled people a forum to describe themselves, serves to restrict and, in part, prescribe how a person constructs their own experiences. Similarly, McLeod (1993) suggests that the 'truths' found by scientific research in fact reflect social expectations, in turn reinforcing their own presumptions.

Thus psychological practitioners, including counselling psychologists, should be mindful of the assumptions inherent to some traditional theories. As has been discussed above, Erikson's theory of psychosocial development has certain assumptions regarding normality and abnormality at its centre, and is based on certain epistemological precepts that serve to legitimise its assertions regarding 'normality'. Thus, psychology needs to open up new ways of exploring diversity, especially concerning disability. McNamee and Gergen (1992) suggest that new narratives are needed to challenge the 'disabling construct' that has been perpetuated through traditional psychological discourse and allow individuals to transcend the disabling role that they are placed in within society. They assert that hierarchical models (such as Erikson's) serve to reduce a person's identity, defining them by their prescribed
label. McNamee and Gergen (1992) suggest that we need to socially re-examine the misconceptions that have caused segregation of disabled people and, in doing so, give the opportunity for positive reconstruction of identity. In order for psychologists to do this they need to be aware of some of the historical assumptions embedded in psychological theory (Sutherland, 1981) and of alternative disability discourses, such social explanations of disability. This perspective differentiates physical impairment from disability (Shakespear, 1993) and perceives disability as stemming from barriers that socially and physically exclude disabled people from society (Oliver, 1996). Such models provide psychology with alternative theories to consider in order to develop new theory and practise.

**Conclusion**

In conclusion, psychologists need to be aware of the inherent assumptions embedded in some of the traditional theories that inform teaching and practise within the field. This would highlight potential discriminatory representations or dichotomies that serve to define diversity as deviance or abnormality, which in turn segregates and stigmatises those falling into this category. Therapeutic practitioners, including counselling psychologists, need to be aware of representations of disability inherent to traditional psychology and how these may impact upon their own perspectives and therapeutic practice. In turn, it needs to be considered how such assumptions and representations may impact upon disabled people in order that this can be explored and alternative representations of disability considered. Therefore, in order that clients are able to create new meanings, psychologists and the institutions which they work, research and learn in, will need to consider the representations of disability embedded in them.
References


How do you understand the term 'therapeutic frame' and how is it important in therapeutic work?

Introduction

The concept of a 'therapeutic frame' was first used by Milner in 1952. She suggested that as an artist uses a frame to contain and give boundaries to a piece of work, in the same way the therapeutic frame defines and shapes the process of therapy. Milner (1952) suggested that in both cases the frame's importance is not noted until something spills outside of it. During the last fifty years there has been some diversity in how the 'therapeutic frame' has been conceptualised within Psychology. Nevertheless, there seems to be some broad agreement that it relates to that surrounding and defining therapy. However, what this actually means seems to be open to some interpretation, in part according to therapeutic orientation and personal style. There seems to be some considerable overlap between the notion of a therapeutic frame and a therapeutic contract. However the term therapeutic frame will be used here as it indicates the psychodynamic focus adopted. It will be considered what elements are involved in this understanding of the therapeutic frame, inclusive of why the notion of a frame is important and why breaks in it can be detrimental.

The Frame and its Function

Gray (1994) conceptualised the frame as 'the rules of engagement within therapy'. She asserted that this should be agreed upon collaboratively, between therapist and client. She suggested it should be comprised of arrangements such as the location of the meetings, duration of sessions, a fixed appointment time, fees paid (when applicable), holiday breaks, protocol for missed appointments and confidentiality. There is nothing to bind therapist and client to these rules, but Gray felt without them confusion may arise. Bateman and Holmes (1995) suggested that an additional function of the frame is to make explicit the process of therapy. They asserted that it is important to outline to the
client, objectives, expectations, and possible difficulties so that future misunderstandings are minimised. Wolfe and Dryden (1990) suggested that this should happen within the assessment session and that treatment should not begin without it. It has even been suggested that the therapeutic relationship only begins when the patient and analyst define the therapeutic frame (Casement 1991). Gray (1994) asserted that the frame prevents the therapist's own issues from affecting the process of therapy, whilst also providing a 'holding environment' for the client. She suggested that it ensures that the client does not have to deal with the therapist's own anxieties, thus are free to deal with their own. However this should not be taken to extremes as, to try and erase the therapist's presence and reactions, may mean missing out on useful insights provided by attention to issues of counter transference. Kahn (1997) felt that in order to make therapy safe and useful the special nature of the relationship within therapy must be respected. Thus the frame creates a boundary, defining what is inside, i.e. the therapeutic relationship and what is outside i.e. every day reality. In traditional psychoanalytic work what is considered to constitute the frame could be regarded as quite rigid; for example, the use of free association several sessions a week, and long term therapy. Furthermore it could be that such rules, if overly rigid, may lead to overlooking the client's experiences of therapy.

However, sticking to an agreed frame can also be very positive. Gray (1994) suggested that practical boundaries, such as a regular session time can provide certainty to the client, letting them know they are valued. For example, a client I worked with asked if the time of her session could be changed, which at the time I thought would be helpful to her. However, later on the client repeatedly mentioned a mistrust of professionals and it seemed that she did not feel safe enough in the sessions to truly express her emotions. This may have been because my changing the frame had been experienced by her as 'uncontaining'. Before this could be dealt with she discontinued the therapy. This could be linked to Bateman & Holme's (1995) assertion that protecting the analytic hour provides a sense of 'being held' for the client. Also, a regular time may help the client to feel contained as it highlights the fact that time has been set aside for them, regardless of whether they turn up or not. Gray (1994) felt that because of this there should be clear
protocols for what happens if sessions are missed. She suggested that if a client is not charged for a missed session they may feel that the therapist does not care if they come or not. This may have implications for unpaid therapists or salaried therapists where different rules may apply.

In addition, sticking to such boundaries also shows the client that the therapist has their own needs, which will have different implications for each client. Furthermore, a therapist asking a client to wait a week may show the belief that they trust a client can survive by themselves. However some clients will not be able to tolerate such boundaries, as it means denying fulfilling their immediate needs. For example, a client I worked with expected therapy on demand every time she had any kind of emotional fluctuation. Her inability to stick to a contract and my refusal to speak frequently to her on the phone, or give her extra sessions led to a break down in the therapeutic relationship and she eventually stopped coming without a formal ending.

Gray (1994) also saw the frame as important in the 'here and now' relationship, ensuring congruence between the therapists words and actions. It establishes a basic ethical practise, ensuring that a therapist does not take advantage of the client (Bateman & Holmes, 1995). Also the practical aspects of the therapy, although familiar to the therapist e.g. the buildings layout, length of therapy, fees paid etc. may be alien to the client. Familiarising a client with such information aims to make them feel more collaborative in the process.

**Diverse Frames**

The content of the frame will be affected by the approach it is being applied to. For example, the more humanistic therapies may use the setting of a frame to clarify the nature of the relationship, boundaries and responsibilities, as this is in keeping with a client centred approach (Rogers, 1957). This differs so considerably to a psychoanalytic interpretation of the frame, that it may be considered to constitute a break in it. For example, the practising of a client centred approach is likely to omit or even disagree
with some psycho dynamic aspects of the frame such as the notion of the therapist as a blank canvas, and the rule of abstinence. However, as therapeutic approaches evolve, so will what constitutes the therapeutic frame. Also if the frame is beneficial to both client and therapist and is negotiated collaboratively then it, by nature must be flexible.

The idea of collaboration regarding the definition of a frame in therapy raises the issue of consent. The client's autonomy should be reflected in the nature of the frame surrounding the therapy in which they are engaged. The British Psychological Society stress how important it is that the client should be able to give valid consent, understanding the frames content and possible consequences of the therapeutic work (Wolf and Dryden, 1990). Bloch (1999) asserted the importance of mutual agreement on processes, which may dramatically affect a client's life. Therefore any therapist is obliged to clarify for their clients the boundaries of the frame. This may be particularly significant in psychodynamic work, which has come under criticism for maintaining a power imbalance between client and therapist. There are some circumstances where particular attention needs to be paid to the issues of consent, for example a learning disabled client. It may be that such a client's support workers are involved in the process of consent (Kitchener, 1984). However this needs to be done with caution so as not to undermine the client's autonomy. Autonomy has been acknowledged as an important part of any therapy, alongside client's fundamental rights, dignity and worth (Wolfe and Dryden, 1990). Thus the frame should protect these aspects for the client. Gray (1994) discussed how Freud believed that the therapist became a figure of overwhelming importance due to the therapeutic process and that the frame protected against this being manipulated or misused.

**Limitations and breaks in the Frame**

There seems to be general agreement that it is important to make the client aware of the frame and its implications, however there is a balance to be struck due to the risk of it interfering with the therapeutic relationship or practise. If the first session comprises of overloading a client with information they may feel overwhelmed or simply not listened
to. Also the frame should serve to enhance a client's understanding, so overly complex language should be avoided. It should also serve to deal with any anxieties or concerns based on misperceptions of what therapy involves which may have detrimentally affected any future work. However the idea of collaboratively constructing the frame may cause some conflict if working in a traditional psychodynamic model. To adopt a teaching or informative role in the first session may conflict with the psychodynamic technique of the therapist being 'a blank canvas' which is used to aid the process of transference. It may also be important to consider the limitations of the frame in terms of what it covers.

For example, communications with colleagues, and what happens outside the session, e.g. if client and therapist meet in the street. Gray (1994) suggested that the frame should be a consideration from before the first session begins, i.e. from the initial point of contact. The first letter, phone call or first meeting with a receptionist should be attended to. For example, when I worked in a large GP’s surgery on placement, there were many receptionists who might deal with my clients. It was extremely difficult for me to control the interaction they had with clients, which contributed to breaks in the frame. For example, it they failed to inform me that a client had arrived then sessions started late. This may have made the client feel that I was unavailable and have made it seem that time has not been set-aside exclusively for them, which was mentioned earlier as an important aspect of therapy. In addition, occasions arose when the receptionist failed to give clients advance notice when I was absent due to illness. One client arrived at the surgery to find I was not there and never returned to therapy after this. Therefore both of these instances seemed to have had a detrimental effect on the therapeutic relationship.

Confidentiality is an integral part of the frame and the therapist needs to be clear regarding the limits of this aspect of the frame. That is, although Gray (1994) appreciated that the therapist needs to be able to contain a client’s anxieties, she also saw the need for supervision. However the undisclosed use of a supervisor could undermine the trust and containment inherent to the therapeutic relationship, which in part is provided by the therapeutic frame (Wolfe and Dryden, 1990). Confidentiality, as well as being integral to a good therapeutic relationship also has ethical and legal implications. How open a therapist or trainee is about supervision etc. is still the responsibility of the individual
clinician and may be affected by how strictly they stick to traditional psychodynamic approaches. However, an ethical boundary is needed that both protects the client and facilitates practise.

Gray (1994) suggested that more may be learnt about the therapeutic work from a break in the frame than from when it is strictly adhered to. She feels that flexibility in the frame is needed, stating that abstract rules lose meaning if they do not consider the human behaviour they stem from. She goes on to suggest that an imposition of objective rules, without consideration of the client will only serve the therapist and undermine the relationship. Gray (1994) suggested there should be two, parallel sets of rules, one unbreakable, one tailored to the individual client. Bateman and Holmes (1995) saw that to ignore the practical needs of a client, betrays the spirit of the agreement. For example a client I worked with was referred to me whilst he was off work with a shoulder injury. Our original appointment time was during working hours. Four weeks into the therapy he returned to work. Therefore it was decided to move the appointment time to late afternoon in order to accommodate his working day.

Nevertheless Bateman and Holmes (1995) asserted that the contract should only be changed by mutual agreement, giving therapist and client equal responsibility to uphold the agreement. Bloch (1999) felt that any changes made should not be done on impulse and should be thoroughly worked through. Nevertheless, Winnicott (1977) actively broke the frame, e.g. giving therapy on demand. Ferenczi (1986) asserted that boundaries may have to be moved to 'unstick' therapy. Ferenczi (1986) felt that therapists had the right to experiment and deviate from the rules, feeling mistakes would become obvious. Winnicott (1977) made the important point that both therapists and clients are human beings foremost, therefore there will always be breaks in the frame to some extent. Furthermore Bateman and Holmes (1995) felt that breaks in the frame may stimulate new material. Casement (1991) stated that breaks in the frame and their implications may only be considered retrospectively. He felt that the therapists own 'internal supervision' should ensure the maintenance of the frame, stating that the boundaries are necessary to create a neutral space in which the client can develop.
Conclusion

It would seem that what constitutes the notion of a therapeutic frame is varied, a reflection of the fact that what is considered as central to the therapeutic process differs according to theoretical orientation. Despite this, it would seem that there is agreement that practical considerations and expectations of therapy need to be clearly negotiated with clients early on in therapy. Furthermore there are some key elements agreed upon pertaining to ethical and safe practice. Nevertheless, there would seem to be a sense that flexibility is needed in order to keep the client's welfare as central to therapy, and an agreement that breaks in the frame may help with an understanding of the process if treated wisely. Thus although it is important to strive for a safe, contained way of practising, it should be remembered that therapy is primarily human interaction with all of the inherent uncertainties.
References


Discuss an aspect of the therapeutic relationship in relation to psychoanalytic ideas

Introduction

The therapeutic relationship is recognised as central to the work of therapy by all psychodynamic approaches (Lemma-Wright, 1995). An aspect of this relationship, recognised by Freud in 1905, is the phenomenon of transference. Although this is understood and used in slightly different ways amongst the therapeutic community it is a central tool of psychodynamic and psychoanalytic work. It highlights the relational nature of therapeutic work and issues regarding the therapist's role within therapy, including the impact they have upon it. Such considerations have spread far beyond the field of psychoanalysis. This essay will give a brief consideration of what is conceptualised as transference. It will then be considered how it may be used in therapy, using clinical examples. Some attention will then be given to the benefits, but also the possible drawbacks, of having transference as a central method of therapy.

What is transference?

Freud first noted a 'transference reaction' when treating Dora in 1905. It has been defined by Greenson (1994) as "the experiencing of feelings, drives, attitudes, fantasies and defences in the present which are inappropriate to that person and are a repetition, a displacement of reactions originating in regard to significant persons of early childhood" (p.33). Freud defined different types of transference such as transference neurosis and narcissism neurosis (Freud, 1916). He originally saw what he later came to refer to as transference neurosis as dangerous. He originally regarded the phenomenon as a hindrance to therapy (Bateman and Holmes, 1995) and felt that the work needed to be freed up from it, only attending to it if it interfered with the therapy. However, in 1909 Freud changed his perception of transference and remarked that it could be a therapeutic tool rather than an obstacle to analysis.

Freud saw that transference existed from the beginning of therapy to a greater or lesser extent and that it involved re-enacting past experiences through the relationship with the therapist. However, Greenson (1994) argued that using the term
'transference' makes it sound like a singular phenomena when it is more complex than that. Greenson (1994) suggests that an enduring feature of transference is that it is always inappropriate in quantity, quality or duration although it may have once been appropriate to someone in the past. Symington (1986) asserts that transference is concerned with two areas. Firstly, with important figures of the past and how they relate to the client and, secondly, to currently repressed and unbearable reality. Fenichel (1941) sees that transference is part of all relationships to some extent but Freud (1957) suggested that only problematic negative transference is usually attended to. An example of this would be that if a person struggled with sibling rivalry as a child they may experience peers as competitive and threatening as an adult (Kahn, 1991).

Transference interpretation deals with bringing the unconscious into the conscious and finding the childhood roots of present problems and repeating the original relationships in order to change patterns of behaviour (Freud, 1922). Transference seems to be primarily unconscious, meaning the person may be unaware of it, experiencing it as feelings, drives, wishes, fears, fantasies, attitudes and ideas (Greenson, 1994). Thus, a therapist in the present is reacted to as if they were a person from the past. For example, a client I worked with had struggled as a child to please her parents. When she was sent away to boarding school in another country she felt that this was punishment for not being a 'good enough' daughter. In therapy the client sometimes seemed overly keen to please me as a therapist, feeling anxious that she would not be a 'good enough' client and fearful that I may find her boring or unimportant and would end our sessions together. Thus, she seemed to relate to me as a disapproving parent.

Despite Freud's original misgivings all psychodynamic schools now hold the relationship between analyst and client as central (Lemma-Wright, 1995). Thus the transferential aspect of the relationship is also central to the work. However, how transference is perceived and worked with differs according to theoretical orientation. Kline (1973) saw transference as relating to projections and introjections. The former involved the client projecting feelings onto the therapist in order to avoid experiencing them. The latter involved internalising good and bad objects (objects
being someone or something you relate to). Although transference is seen as the hallmark of psychoanalysis other theoretical stances use similar concepts. For example, interpersonal approaches highlight the importance of acknowledging that both the therapist and the client contribute to transference, whilst ego psychology would conceptualise it as an expression of instinctual wishes (Bateman and Holmes, 1995). There are some real differences in how transference is used but some are just semantic differences. Therapeutic orientation, as well as therapist's idiosyncrasies, will affect which aspects of transference are emphasised.

How transference can be used clinically

Transference can aid therapeutic work by helping a therapist gain insight into the client's unconscious and thus provides a way of accessing unresolved conflicts and issues. Symington (1986) views transference as a useful tool of therapy, aiding an understanding of the client, but asserts that it cannot be taught academically. Greenson (1994) states that scientific and intellectual theory, as used by the therapist, cannot work with the unconscious, so must be brought into the conscious. The therapist also needs to work in a flexible way that can take account of the symbolic nature of the unconscious (Greenson, 1994). Freud (1957) used hypnosis to access the unconscious but realised that this could also be accessed through the transferential relationship. Through the process of transference the therapist is given clues as to what the client needs. This means that the therapist has to grow with each client learning their needs as each client will have an individual past (Symington, 1986). Transference can also provide insight into how the client's unconscious material may affect their ways of relating in everyday life. For example, I worked with a client who had left a session angry with me and then the following week I was off sick. Meanwhile, a support group I had organised for her to go to had to stop running. In the following session, rather than being angry, she was very polite and cheerful. However, her body language was tense and she spoke about other people who had made her angry but who she felt she could not tell. Attending to this allowed us to explore how she may have been masking her anger towards me and thus how she may do this in other relationships. It also facilitated an exploration of some of the reasons
why she may do this. For example, she is scared of being rejected if she shows her anger.

Therefore, transference can give a therapist an opportunity to access the unconscious and non-verbal material the client brings. Another example of this can be seen in the work I undertook with a client who was acting in a very protective way towards me. She would offer me sweets, ask how I was, bring her own tissues to the session so I didn't have to put any out for her and protect me from her sad emotions. Reflecting on this allowed us to explore how she had protected her mother her whole life, by not disclosing the sexual abuse she suffered from childhood.

Psychodynamic theory considers how people develop psychological strategies in order to defend themselves emotionally. These in turn may block the therapy from exploring any past material that is unpleasant or painful. Therefore, attention to transferential issues can enable a therapist to attend to what is not said in therapy, which can be just as important as what is said. For example, I worked with a client who was unable to verbalise his anger in the session, despite seeming very frustrated and angry. Reflecting on this with the client allowed us to explore how it may relate to him feeling unable to be angry with his dead father because of his own guilt and belief that it was his anger as a child that caused his father's death. Thus, the therapy reflected on his lack of expressed anger, in contrast to the felt anger, displayed towards others in his life and towards me in the transference. However, during this work the client often experienced going blank mid sentence and forgetting what he was going to say which may reflect a strong unconscious defence, stopping him from going into material that may cause him emotional distress.

Bateman and Holmes (1995) suggest that a more flexible conceptualisation of transference is needed. That is, rather than the traditional understanding of transference as confined to past, usually infantile neurosis leading to adult pathology, expanding it to include a consideration of how the expectations and experiences of the present are affected by the past. They do not recognise transference neurosis as a simple pathway to cure, rather seeing a broader concept, recognising the interplay between therapist and client. Thus, they suggest that the client's internal drama can be
played out with the analyst. However, they still perceive transference as central to accessing the unconscious and providing the therapist and client with deepened insight.

**Counter-transference**

The occurrence of counter transference has been widely discussed within the therapeutic community. That is, the therapist's own feelings relating to the therapeutic work, either stemming from the client or from their own past experiences (Stern, 1924). For example, a therapist may feel maternal towards a client either because of the client’s need (e.g. they never felt loved by their mother) or in response to the fact that the client reminds them of their own child. Freud (1957) errred caution with such reactions, suggesting that this could lead to a 'blind spot' developing in the therapist if they were not aware of how their own issues may affect their ways of relating. Originally, as with transference, Freud (1922) thought that counter transference should be avoided, but similarly it became seen as a useful tool in therapy. Thus, Freud (1922) asserted that the therapeutic work could not go beyond the therapist's own complexities and defences (Jacobs, 1999). This is why he saw it was essential for any therapist to undergo their own analysis in order to be aware of their own issues. It is important to consider the impact that the therapist’s reactions have on the relationship. Traditionally, the therapist was seen as a blank canvas on which past images could be shown. Ferenczi (1921) was one of the first to challenge such traditional views of the therapist, advocating greater acknowledgement of the therapist's part in the relationship. Sandier (1969) highlighted the effect that the therapist's qualities have on the therapeutic interaction. Thus, the client will react to the therapist partly as he or she is as well as how he or she is seen transferentially (Bateman and Holmes, 1995). This introduced the idea that a therapist's own thoughts, ideas and feelings were helpful to the therapy. However, this caused a split within psychoanalysis, some believing that all the therapists felt was the client's projections and some advocating this new stance which asserted that therapy was a collaborative, co-constructed process (Joseph, 1985). This shift in position put into question the notion of the therapist as an objective, detached observer. Ferenczi (1919) felt that some disclosure regarding the therapist's subjective experiences could
be useful for both the client and therapists progress. However, this assertion is still contested strongly within the psychoanalytic field. Strachey (1934) stated that attending to counter transference issues enables the relationship to foster a feeling of mutuality and closeness, which is essential to the work. Balint and Balint (1939) suggest that it is inevitable that an analyst will show aspects of themselves through their way of working, rendering objective anonymity impossible. Contemporary schools of thought, such as constructionist and interpersonal approaches advocate acknowledging the subjective experience of therapy. Such stances assert that as it is impossible to eradicate the therapist's influence on the session, it should be instead acknowledged and made apparent, learning from what is constructed within the therapeutic interaction.

**Limitations of transference**

Bateman and Holmes (1995) assert the need to acknowledge that the version of past events that is constructed in the therapy is from the perspective of the present. This is in opposition to the traditional concept of transference, which was seen as an accurate repetition of past events, void of any distortions of fantasy (Kemberg, 1987). Bateman and Holmes (1995) conversely see that the experiences brought into the session are useful, despite their relationship to past reality, because of how they may be used to facilitate change in the client's understanding or perspective of the past.

Perhaps a balance is needed, of accepting that the client will provoke certain reactions in the therapist whilst not denying that the therapist will have their own issues too. Although transference can be a way of accessing the unconscious and the past and deepening insight there is a fine line between acknowledging the transference aspect of the therapy and becoming 'therapist centric'. That is, being aware of what lies outside the transference relationship. For example, a client being cross with the therapist may stem from the therapist acting inappropriately, rather than from the client's transference. Greenson (1994; p.158) gives an example of a therapist falling asleep in a session and when being woken by an angry client interpreting that the client must have wanted him to go to sleep. Also, Casement (1985) reminds us that emotional relating is part of all relationships and the therapist should be able to split off what is
thiers and what is the clients, knowing what belongs to whom. Being aware of oneself should mean that the therapist's perceptions should not be overtaken by the client's unconscious (Greenberg, 1982), thus maintaining the ability to take in and detoxify the client's material (Bion, 1952).

Furthermore, transference relies on the therapist's interpretation, which means to some extent what is focused upon within therapy is chosen by the therapist (Bateman and Holmes, 1995). Furthermore, the therapist is not beyond acting defensively themselves, and may avoid material they find difficult, despite any benefit for the client. Furthermore, the possible power imbalance within the therapeutic relationship may leave the client vulnerable. For example, if there is an erotic transference (as described by Freud, 1922), and if the therapist is either unethical or unaware of his or her own counter transference an inappropriate relationship may be formed. The therapist could choose to hide behind their transference interpretations, not taking any responsibility for their actions or their impact on the therapy. There needs to be room for a 'real relationship' containing a contract and rapport, allowing work to be done (Lamma-Wright, 1995). The transference, although important, should not take over all aspects of therapy which keep the therapist and client safe. Similarly, the reality of a therapist's reaction to a client should be attended to (for example, a therapist may feel scared because the client really is a threat). Furthermore, despite transference allowing certain material to be accessed in therapy it may hold it's own difficulties for the therapist. This is because it may be hard to accept the perceptions of the client's inner world, for example, to tolerate feeling misperceived or seen in opposition to how we wish to be viewed by others (Symington, 1986). Furthermore, although the active repetition of a traumatic event may lead to a sense of mastery over it for a client it could be difficult for the therapist. For example, if the repetition of past events meant being related to as an abuser, or in a way that the therapist has struggled with in their own live. Greenson (1994) also suggests that as much as transference is a good tool it may block the adult work of therapy by trapping the client into a certain way of relating or viewing the therapist. Also, although transference has been spoken about as a static phenomenon here, it is not necessarily so. It may be ambivalent in nature and Clover (1955) names 'floating transference' to describe the inconsistent and whimsical nature of transference, especially in early therapy.
Conclusion

It seems that transference has a clear place and benefit in the practise of psychodynamic therapy. Although being used in different ways according to the therapeutic approach it seems to provide a way of accessing material in the therapy that could not be dealt with in a purely intellectual, verbalised way. It seems to provide a tool for considering a client’s past experiences in a way that allows them to be processed and perceived differently. However, transference interpretations may be dangerous if the therapist does not acknowledge the co-constructed nature of therapy, i.e., their reactions and influence. If counter transference is not attended to the transference could be used to mask the influence of the therapist on the therapy, inclusive of their shortcomings. There is also the concern that the power imbalance within therapy means that the transference interpretations could be used unethically, either to highlight material according to the therapist’s agenda or to exploit vulnerable client’s. However, if the phenomena of transference is used responsibly, in conjunction with an acknowledgment of the potential ways a therapist’s own counter transference impacts on the therapy, it can be a powerful tool in uncovering unconscious material and considering past and present ways of relating.
References


In cognitive therapy, how would the therapist understand and work with difficulties that arise in the therapeutic relationship?

Cognitive therapy is based on the principle that our thoughts have a profound impact upon our emotions, behaviours and physiology (Gilbert, 2000). Thus, our thinking styles can affect how we interpret the world. These biases in how we perceive the world can in turn mean we perpetuate and maintain our problematic ways of behaving in everyday life. Therefore, in its simplest form, cognitive therapy is based on identifying and changing these problematic thinking patterns. Cognitive therapy has gained much support due to the plethora of research undertaken pertaining to its effectiveness. It lends itself well to such research, as it is based on clear techniques and protocols. In part due to this, the therapeutic relationship has been less associated with the cognitive approach than with other approaches (Frank, 2002). However, as the collaborative nature of cognitive therapy is central, the relationship must also be a key concern. This essay will explore some of the reasons why the therapeutic relationship is important in cognitive work. It will then go on to look at how problems in the therapeutic relationship, rather than being detrimental to therapy, can be used to gain insight.

The therapeutic relationship has traditionally been more associated with a client-centred or psychodynamic approach than a cognitive one. However, Frank (2002) feels that on closer inspection the relationship is just as central to cognitive work. Woolfe and Dryden (1998) agree, stating that the therapeutic relationship has received less attention than the technical aspects, not because it was seen as unimportant, but rather because it was taken for granted that a good relationship was necessary (although not sufficient) for therapeutic change.

The therapeutic relationship became an overt concern in cognitive work when the approach was developed for use with clients with personality disorders (Woolfe and Dryden, 1998). Further to this, Waddington (2002) asserts that cognitive therapists have been encouraged to give more attention to the relational aspect of the therapy because research from other therapeutic approaches has shown that the relationship
has an impact on therapeutic outcome, independent of technical interventions. She reviewed some research, which looked at the role of the relationship in therapeutic change (for example, Castonguay, Goldfield, Wier, Raue and Hayes, 1996; Muran, Gorman, Safran and Twining, 1995; Rector, Zuroff and Segal, 1999). She concluded that "in summary an association between the therapy relationship and outcome has been observed more often than not" (p. 184). However, she cautioned that such research could not be relied upon without asking some further questions, such as when the measure is taken during a session, who it is rated by and what it measures.

Frank (2002) asserts the need to find a way of incorporating more of a focus upon the relationship into a cognitive approach by integrating it with other approaches such as a psychodynamic one. However, some (such as Joiner and Rudd, 1997 and Safran, 1990) feel that cognitive ideas do not easily incorporate the more traditional ways of conceptualising the relational aspects of therapy, and that a new way of thinking about the relationship is needed that will enable the fundamental principles of cognitive work to be retained. Such an integration has been attempted by some theorists such as Safran (1990), who adapted a schema-focused approach to develop an interpersonal schema.

A schema in cognitive therapy refers to a belief system that an individual develops, which determines how they think about themselves, others and the world (see Beck, 1996). Young (1994) defined schemas as being "extremely stable and enduring themes that develop during childhood and are elaborated upon throughout an individual's life time." (p. 7). Safran (1990) describes an interpersonal schema as "a generic knowledge structure based on previous self/other interactions which contains information relevant to the maintenance of interpersonal relatedness" (p. 102). Thus, he argues that such schemas will guide our ways of relating. Also, Joiner and Rudd's (1997) work on 'The therapeutic belief system' similarly develops a way of incorporating attention to the therapeutic relationship into a cognitive approach. Frank (2002) asserts that therapy, as a discipline, has come to realise that the therapist has no choice but to be in relationship with the client and thus the relationship's influence on the therapy must be considered.
Therefore, it seems that the therapeutic relationship is becoming increasingly salient to cognitive work. Before we move on to look at how problems within the relationship can be utilised clinically it may be useful to give some brief thought to how a good therapeutic relationship is useful clinically. Beck et al. (1990) suggest that the therapeutic relationship is an important source of reinforcement for clients who cannot easily utilise the more technical interventions associated with cognitive therapy. Also, the relationship can be used to foster a sense of hope in the client which Snyder, Michaels and Cheavens (1999) see as essential for therapeutic change. McNiel and May (1987) assert that if the client regards the therapist in a positive way they are less likely to drop out of therapy, as well as being more likely to be satisfied with and, thus, gain from therapy. Waddington (2002) suggests some ways in which cognitive therapists can work on improving their relationships with their clients, inclusive of seeking the client's perspective on the work and the relationship, collaborative agenda setting, attending to generalisation from the therapeutic relationship and attending to ruptures in the relationship. Furthermore, Safran and Segal (1990) assert that the therapeutic relationship can be used to disconfirm dysfunctional beliefs developed early on in life about self and others, helping clients to evaluate and change them. They regard ruptures and repairs in the relationship as a critical part of this experience.

This brings us to the main focus of this essay, which is to consider how problems in the therapeutic relationship can be understood and worked with. The idea that clients’ negative reactions to a therapist or the therapy may provide therapeutic insight can be traced back to the idea of transference used in psychodynamic approaches. This has been conceptualised as a client having feelings towards a therapist, which are inappropriate to him/her. Rather, those feelings are a repetition or a displacement of reactions, originating from other significant experiences or relationships in their past (Greenson, 1994). Increasingly, it is acknowledged that the therapist’s, as well as the client's reactions to the therapeutic relationship are also significant to the work. This concept has been used in psychodynamic work and referred to as the counter-transference (see Freud, 1922). Kernberg (1965) defines it as "the therapist's unconscious reactions to the patient's transference". At first, such negative or difficult aspects of the therapeutic relationship were seen to be purely detrimental (Bateman
and Holmes, 1995). However, it came to be felt that such problems in the relationship might be central to any work done in therapy.

Therefore, such negative feelings or actions on the part of either the client or therapist in cognitive therapy could be important in gaining therapeutic insight. Woolfe and Dryden (1998) assert that the relationship can be particularly important when working with specific client groups. For example, a client with an avoidant personality may see the therapist as critical and demeaning, as this is how they see others more generally, thus the relationship could be used to examine what expectations the client brings with them to therapy. For example, a client I worked with felt much resentment and anxiety towards me in our sessions. On exploration, it seemed that the client had developed an early maladaptive schema relating to being rejected. This may have stemmed from feeling rejected by her parents after their divorce and this led to a fear of being rejected by me. Therefore, engaging in therapy and thereby in a relationship with me felt risky for her as it exposed her to the threat of being rejected again. This allowed us to explore how this repeated a pattern she seemed to have developed, where she isolated herself in an attempt to protect herself from being rejected. The result of this was, paradoxically, to make her feel more alone and isolated.

Cognitive therapy aims to access a client’s beliefs on three levels, i.e. automatic thoughts, underlying assumptions and core beliefs (or schema). Thus, identifying problems in the therapeutic relationship can help to provide examples of distortions in these three areas and give clues as to how the client relates to others more generally. This seems to fit well with the cognitive focus on the here and now issues, as this approach places less emphasis on a client’s past, instead focusing on how the client is perpetuating their present problems (Clark, 1995). Therefore, the therapeutic relationship, being the most present thing in a session, is an ideal place for testing out any assumptions distorted by a client’s core beliefs (or schemas). That is, a client will perceive their daily interactions, in this case the therapeutic relationship, according to their core beliefs (prescribed by their schema). This may manifest itself as a distorted or exaggerated perception of what a therapist says or does. Thus, such a reaction can be used to explore the underlying beliefs a client holds about themselves, others and the world in general. For example, I worked with a client who was very engaged in
therapy, motivated and keen. However, one session she mentioned that she had done the homework (relaxation) the evening before because she knew she was seeing me the following day. This elicited a discussion about what motivated her to be so engaged in the therapy. We explored her automatic thoughts and underlying assumptions regarding therapy, which related to how I viewed her. That is, she was doing the tasks for me, in order to be a good client and in her own words 'sparkle' for me. When we unravelled this further it came to light that the client felt that she had to always be interesting and successful in order that people would love her. She had thoughts such as 'if I am not interesting people will not love me'. However, her conditional assumption of 'if I am perfect people will love me' had served to protect her from this fear. This enabled us to explore some possible core beliefs or maladaptive schemas, which involved her deepest fear, i.e. that she was unlovable. This is a particularly complicated scenario as the problem in our relationship was that it was too good, that is, she was too compliant and willing to please me. This was not immediately obvious, as I would leave the session feeling we had done some good work. However, underlying this was the fact that she was unable to 'do' for herself out of a fear of being rejected. Thus, in this case the evidence that there was a problem in the relationship was that it was 'too good' indicating that the client was putting the therapist's needs before her own.

Safran (1990) suggests that his concept of an interpersonal schema can be used to identify maladaptive schemas, which constitute the cognitive part of client's interpersonal cycles. That is, it can be considered how dysfunctional interpersonal patterns are maintained by reflecting on the therapeutic relationship. These two realms of cognitions and interpersonal patterns can perpetuate each other. That is, one's beliefs effect how stimuli are perceived, in turn, changing how a person behaves. Young (1994) asserts that a client will feel that they cannot avoid the beliefs embedded in their schemas from coming true, thus information will be distorted through cognitive manoeuvres, reinforcing their beliefs. In the above example the client's fears of not being interesting enough may have meant that she looked for signs that she was not good enough or was boring to the therapist. For example, she may perceive the therapist checking the time as evidence that she is boring, rather than it meaning that the therapist had to check how long they had left in the session.
Young (1994) states that "one of the most potent methods for changing schemas is through changing the therapeutic relationship itself" (p. 38). He asserts that the therapist needs to be alert to any indications that the client's schemas are being activated in relation to the therapist. He suggests that the relationship can be used to test their schema and he sees that this may need the therapist to disclose to a certain extent or to actively 're-parent' in order to repair the effects of old maladaptive beliefs stemming from schemas e.g. others will reject me. Waddington (2002) suggests that dealing with any problems or complications in the therapeutic relationship, as well as helping with the client's specific schematic beliefs, can also let the client see that a problematic relationship can be survived and worked through. This has implications for introducing new ways of behaving which may be useful to the client in their everyday life. Further to this, however, dealing with problems as they happen in a relationship also means that the 'hot thoughts', i.e., those which evoke the strongest emotional reactions, can be challenged (Greenberger and Padesky, 1995).

Allen (2001) suggests that any relationship can provide information about a client's schema, as they will fit their established patterns in some way. For example, a passive person may always choose a dominant partner. This may have implications for the role the therapist plays in the relationship. Joiner and Rudd's (1997) work on the 'therapeutic belief system' suggests that there may be reciprocal roles within therapy, for example, victim and saviour. Therefore, it may not be enough to just look at the client's problematic ways of relating. For example, I worked with a client who struggled to be assertive. She felt pushed about and under pressure from others. I felt that we were working well together and I was keen to keep moving forward with the work. We had identified her automatic thoughts and started to challenge them. However, as the sessions passed she seemed to become more depressed and less engaged in therapy. When I commented on this we reflected on our relationship and it became apparent that she felt under pressure from me. Therefore, although we had identified her passive victim role in her everyday life we had not identified it in the session or my reciprocal, assertive dictating role. When we reflected on this we negotiated a new way of working together whereby the client was able to disagree with me and assert herself in the session. In order for a problematic relationship to be
used in identifying client's schemas the way in which a therapist reacts also needs to be attended to. For example, I worked with a client who always attended his sessions and was very engaged and yet I felt helpless and useless within the session. However, when I considered my reaction it became apparent that what I was feeling was similar to my client's own anxieties about not being good enough. That is, he held rigid rules for himself, and for others that things should always be perfect. This enabled us to reflect on how his expectations may make himself and those around him feel immensely under pressure, as no one could live up to his perfect standards. This enabled us to identify and then to modify the rigid rules he held for himself and to consider how we were interacting.

However, problems in the therapeutic relationship are not always useful indicators of maladaptive beliefs and thoughts. They can also genuinely indicate that something is wrong with the therapeutic work. That is, the reality of a client's reactions or feelings are also important and if they are angry, or not completing homework, it may be because the therapist is not listening to, understanding or empathising with the client. This may mean that the therapist is coming across as unsympathetic or judgmental. Equally, it may imply that the type of therapy is not right for the client.

In conclusion, although this essay has not had time to look at any one use of problems in the therapeutic relationship in great detail, it has considered a variety of alternatives. The relationship in cognitive therapy, as with any approach, seems to be an invaluable resource with which to investigate a client's problematic thoughts, emotions and ways of behaving, as well as providing a way of working with them. The relationship can be used to gain insight into a client's schema, exploring how their beliefs affect their ways of perceiving, both within the therapy and in their every day life. It can then provide an opportunity to challenge maladaptive beliefs and formulate alternatives. Thus, although a good relationship seems necessary to enable any therapeutic change, problems in it can also be used to work with a client in a valuable and meaningful way.
References


THERAPEUTIC PRACTICE DOSSIER
Therapeutic Practice

Below is an overview of the placement work undertaken as part of the Doctorate in Psychotherapeutic and Counselling Psychology. That is, a requirement of the course is to work 1 to 2 days a week as a Counselling Psychologist in training, in different contexts, using a variety of therapeutic approaches. Although written work is undertaken pertaining to this work it is not included as part of this portfolio so as to maintain the confidentiality of those clients who agreed their material could be used. In addition all details of the placements have been omitted to further ensure confidentiality.

First year placement

This placement involved working one to one and a half days a week in primary care. That is, I worked in a counselling service attached to a GP’s practice situated in a suburban area. It was a large practice, having a catchment area of three miles and 12,000 registered patients. The surgery was staffed by 7 doctors, 12 nurses, 1 psychiatrist, 2 opticians, 1 dietician, 1 chiropodist, 1 chiropractor, and 3 therapists (including myself and a chartered counselling psychologist who supervised the work that I undertook).

The practise was in an economically deprived area, which seemed to have an impact on the client's issues in the respect that the socio-economic context was often relevant to their presenting problems. It was a busy practice and space was often an issue. Therefore, I worked in whatever rooms were available. There was a constant stream of referrals from the staff at the practice, although the waiting list was kept to a few weeks.

I worked with a variety of clients, ranging from, depression, anxiety problems, anger management, bereavement issues, abuse, health concerns, lifecycle issues, relational problems and drug and alcohol issues. I used a broadly client centred approach although my supervision was integrative. There was a degree of flexibility in the
duration of therapy, ranging from brief work (six to eight sessions) to working with some clients for the duration of my placement.

Second year placement

Student counselling centre - September 2001 to July 2002

I spent one to one and a half days a week working in the Student Counselling Service, which was based on a university campus. This was comprised of four full time Therapists/Counsellors, a full time Administrator and five-trainee therapists from a variety of courses. Students either self referred or were referred by the campus doctor or lecturers. There was a high demand for this service, from both undergraduate and post graduate students but the service was committed to making waiting lists minimal (no longer than a couple of weeks). However, the number of new referrals fluctuated throughout the academic year.

I adopted a psychodynamic approach during this year and received weekly supervision from a psychodynamic counsellor who worked at the centre. I saw a range of undergraduate, post graduate and mature students during the year. A high proportion of the clients I worked with were overseas students, which meant cultural issues were often central to the work. I worked with clients with a range of presenting problems, including, identity issues, abuse, self-harming, sexual problems, obsessive behaviours, anxiety, stress, trauma and eating disorders. The duration of therapy was dependent on what the presenting problems were and what was negotiated with the client at the beginning of therapy. This meant some of the work was short-term (six to eight sessions) and some were longer term (for the duration of the academic year).

This placement fostered a sense of working as part of a team. Part of this involved meeting on a fortnightly basis to participate in seminars. These were divided into two parts. The first involved a member of the team presenting a case study, which was discussed amongst the group. The second part would involve a topic being presented and discussed. I was able to present several case studies as well as presenting the topics of disability, multicultural practise and the needs of postgraduate students.
Final year placement

Specialist psychology - September 2002 to August 2003

This placement involved working two days a week in a specialist psychology service. This was based next door to the local CMHT (Community Mental Health Team) located in a hospital. I took referrals from both the chronic re-occurring depression service and the obsessive-compulsive disorder (OCD) service. These were staffed by one part time psychologist specializing in OCD, one clinical nurse specialist (who supervised my work) an administrator and myself. The clinics receive referrals from GPs, psychiatrists and the CMHT. The different departments within specialist psychology (i.e. Neuro Psychology, Family Therapy, direct access and Psychotherapy) often liaise with each other as well as with the CMHT. It is a busy service, which often has a waiting list of several months.

This service uses Cognitive Behavioural Therapy (CBT). Therefore much of the work I undertook was shorter term (12 to 15 sessions) protocol based CBT. However, I also began to work in a more integrative way throughout the year (see the clinical paper). This was helpful when working with more complex clients in longer-term work that I undertook (i.e. 20 to 30 sessions). Despite working in the depression and OCD clinic I also saw clients with issues relating to anxiety, stress, bereavement, identity issues and issues regarding self worth. I also met with a Psychologist bi-monthly to discuss issues of professional development as well as attending department meetings. These addressed topics such as, developing a personality disorder service, NHS directives on correspondence, departmental issues and care plan assessments, I also had the opportunity to visit the in-patient ward and participate in a ward round and a care plan assessment meeting.
The evolution of my therapeutic approach

Introduction

When I sat down to write this paper I was faced with a fundamental question; what is therapy? It occurred to me that I had spent much of the three years of my training deconstructing theory and questioning assumptions, as well as developing ideas about how knowledge is constructed. This led me to conclude that no one theory is true or right in its entirety. This meant that I had to take a hard look at what I did have, in order to formulate my ideas on a way of working therapeutically. I concluded that what I did have was relationship and that this was at the core of my therapeutic style. It has been asserted that the quality of the therapeutic relationship is the most significant determinant of psychotherapeutic outcome across theoretical orientation (Clarkson, 1995; Frank, 1973; Orlinski and Howard, 1986; Waddington, 2002). Counselling psychology holds the relationship and the therapist’s use of self as central to any therapeutic work (Woolfe and Dryden, 1996). Therefore, attention to relationship is integral to my professional identity, my clinical work and my way of being in the world.

The exact nature of therapy will vary from client to client and moment to moment and thus I believe that an integrative style of working enables the therapist to adapt to each scenario. Fear and Woolfe (2000) describe the process of integration as a journey in which the practitioner’s personal and professional selves move into some sort of harmony and congruence. Thus, I am drawn to therapeutic ideas that embrace issues of relationship, meaning and context, whilst still allowing me to incorporate the multitude of psychological theory and technique that is essential to my therapeutic work. As I move towards the end of my doctoral course I conclude that my journey hasn't ended, but is just beginning. Therefore, what will be presented in this paper is not a finalised version of how I will work integratively as a therapist but, rather, a summary of the ideas I have encountered that will influence my future work as a therapist. That is not to say that I feel lost or unfocused as I feel that my identity as a counselling psychologist provides a framework into which I can integrate what I have
learned. I believe therapy provides a way for clients to find new meaning regarding themselves, others and the world, as well as facilitating a move towards a more self-fulfilling and authentic existence (Norcross and Goldfried, 1992). I do not perceive clients' issues in terms of illness or pathology, with therapy providing a 'cure'. This provides me with a structure within which to consider issues of ethics, context, theory, practice and selfhood. This paper will follow my development throughout the three years of training and, using clinical examples (with names changed in order to maintain confidentiality), will outline the resources I have developed to use in my therapeutic work.

**The first year**

**Theory**

The first year introduced me to the humanistic way of working, which is integral to counselling psychology (McLeod, 1996). This approach immediately appealed to me because it fitted with the focus on relationship and respect that I already valued. The humanistic paradigm places great value on the 'human capacities and potentialities' (McLeod, 1996), and also views the person as a contextualised and complex whole (Means and Thorne, 1996). It enabled me to develop the three core conditions (empathy, congruence and unconditional positive regard), as well as considering the importance of self-acceptance by client and therapist (Rogers, 1957). This approach also reinforced my belief that clients have the potential for positive growth and change (Kirschenbaum and Henderson, 1990). However, this will be shaped by the resources that they have available to them, which is defined by their social, cultural, political, historical and spiritual contexts. I reflected that what constitutes positive change differs (and thus needs to be negotiated) and can be achieved through a combination of insight and more pragmatic factors.
Placement

I spent my first year working in a large, suburban General Practice. I worked with clients with a variety of presenting problems during this year such as relationship problems, issues of identity and self worth, depression, anger problems, bereavement, abuse and health issues. This placement provided me with a steep learning curve regarding my therapeutic practice, and highlighted the significance of context. For example, I was often moved from room to room due to a shortage of space, which helped me to recognise the importance of the therapeutic frame. It also highlighted how a system designed for sighted people poses problems for someone who is registered blind, such as myself. As well as issues surrounding access to data and writing notes it also meant that I had to rely on staff in reception to inform me that clients had arrived. In a busy practice this is easily forgotten and appointments were sometimes started late due to this. Therefore, I feel this year helped me to develop the way I work practically, as much as how I work therapeutically.

This year helped me to develop my current eclectic style; choosing the best or most appropriate ideas and techniques from a range of models and theories in order to meet the needs of the client (McLeod, 1993). This can be differentiated from integrative work, as defined by Norcross and Goldfried (1992), as a process whereby the therapist brings together elements from different theories and models into a new theory or model. Prochaska and DiClemente (1992) suggest that eclecticism has been compared unfavourably to this definition of integration. However, I feel that eclecticism allows me to attend to each client’s differing needs, although I agree with Norcross and Goldfried's argument that to change between styles may be confusing to a client. Therefore, I seek to find a framework that will guide my practice, whilst giving me the flexibility to be client led.

During this year I developed a focus on the relationship, learning the importance of 'being', rather than 'doing'. This agrees with the assertion that "the most crucial factor in healing is not what we counselling psychologists do with clients but how we are with them" (Woolfe, 2002, p.169). An example of this can be seen in the work I undertook with Ms. Grange who had been referred for some support with a difficult
relationship break up. Ms. Grange seemed to find it hard to speak about her emotions, reporting that this was not what she was used to, as her mother and father were not emotionally expressive. We spent twelve sessions exploring the changes that she wanted to make but described feeling 'stuck'. I struggled at this point, feeling inadequate and unsure. However, after discussion with my supervisor we decided that I should offer Ms. Grange some extra sessions, making explicit that I was going to stay with her in her 'stuckness'. This 'being with' Ms. Grange seemed to enable her to feel safe enough to reflect on some of the ways in which her own anxieties may have been preventing her from making the changes she wanted. This seemed to emancipate Ms. Grange, enabling her to move on both practically and emotionally.

However, 'being with' does not mean overlooking the other aspects of therapy. Counselling psychologists are trained in a range of theory, research and practice and may draw upon implicit and explicit psychological theory (Wilkinson and Campbell, 1997). Thus, I used different approaches, or different aspects of psychological knowledge, according to the specific needs of each client. For example, I used Worden's (1983) grief model when working with bereavement.

I also started to develop some strategies that were useful more broadly. For example, I found Malan's (1979) ideas useful in considering patterns of relating. I also began to draw upon psychodynamic ideas such as projective identification (Ogden, 1992) and transference (Sadler, Holder, Kamenkoa, Kenndey and Neurath, 1969). That is, I began to reflect on how the therapeutic relationship may be affected by the client's past relationships, as well as considering my own reactions to the client. This helped me to reflect on how my own issues may influence my work. For example, I worked with Ms. Kerbey who had been referred for anger management. However, on further exploration, Ms. Kerbey seemed to have developed problematic ways of relating to others, specifically men. These relationships involved inequality, whereby she took much of the responsibility whilst also being controlled. I had to be aware of my own counter transference, in order to ensure my own feminist beliefs did not block my ability to hear the client's perspective. Also, if I had dictated what changes she should make in her relationships this may have led to a repetition of previous controlling
relationships. This placement also helped me to define my own boundaries, both in terms of what I can offer clients, and what I cannot provide.

**Research and personal therapy**

I have put research and personal therapy together because they both contributed heavily to my own personal development. We were advised to choose a research topic that held significance for us. I took this advice and chose to pursue the topic of disability. This introduced me to social explanations of disability (Oliver, 1996). This differentiates physical impairment from disability, perceiving the former as a physical state and the latter as stepping from societal and physical barriers. This had implications for my own identity both personally and politically. In addition, the choice of epistemological stance introduced me to social constructionist theories (e.g. Gergen, 1985; Yardly, 1997). This enabled me to reflect on how meaning and knowledge are constructed and the implications that these have for how I view psychological theories.

I used my personal therapy to consider the many paradoxes and complexities that constructionist ideas cause. This helped to integrate these ideas into my sense of self and my own belief structure, as well as into my therapeutic stance. As alluded to in the theory section above, counselling psychology does not subscribe to the idea that a clinician can 'objectively do' therapy but, rather, tries to make explicit what the therapist brings to the relationship. Therefore, it seemed important to use my own therapy to consider how changes in my life and self-perception might impact upon my therapeutic work. In addition, it helped me to reflect on how it felt to sit in the client’s chair and helped me to consider how my actions may be experienced by clients, i.e. 'trial identification' (Casement, 1991).
The second year

Theory

This year focused upon psychodynamic theory and practice and I entered it with scepticism, due to reservations I had about some of Freud's ideas. However, I left having gained some valuable experiences. To my surprise this way of working sat easily with my personal style and way of being. I found after the anxiety of the first year that this approach enabled me to develop the ability to be quiet and listen. In fact, learning to be with silence was one of the most useful lessons I learnt this year. However, I did not use this approach in a purist way, but rather incorporated it into my developing relational style. This meant finding a balance between making space for the client and being overly reluctant with interventions. It also gave me an opportunity to reflect upon power relations. Previously, I had maintained that the client and I were equal. This year, through the use of group supervision, I came to realise that the therapeutic relationship is inherently unequal. The most ethical way of dealing with this is to acknowledge such inequalities and attend to them by considering with the client how this may impact upon our relationship.

Although I did not accept the psychodynamic perspective on clients' issues and personhood more broadly, (due to its tendency to over generalise and pathologise) many of the concepts helped me to deepen my work. I found the focus upon the importance of early interpersonal relationships, specifically parental ones, helpful (Burton and Davey, 1998). However, I did not feel that this should be adhered to if this did not fit with a client's own understanding. Also I do not agree with Freud's assertion that the unconscious is a tangible phenomenon (Freud, 1922). However, I did find it helpful as a concept in order to construct meaning, and consider what a client might be unaware of, in order to access issues that may have otherwise gone unnoted. Although I used interpretations to share my ideas with the client I was very aware that this approach could perpetuate power imbalance by giving credence to the idea that the therapist holds knowledge about the client, which they impart to them. I strove to avoid this, looking for negotiated meaning. In addition, I felt the use of 'free association', facilitated by the therapist being as neutral or 'opaque' as possible (Freud,
1922), did not fit with my relational focus, which demanded a more genuine and warm relationship. I found that the concept of projective identification (clients projecting their difficult feelings onto me, Sadler et al., 1969) useful, as well as the idea of transference and counter-transference (Freud, 1922). Although I do not adhere to the traditional definitions of such phenomenon, a more contemporary perspective was useful in enabling me to consider how the therapeutic relationship may be affected by past relationships and experiences (Greenson, 1994). I found it helpful to include Symington's (1986) version of transference, which says that current repressed and unbearable reality will also affect the therapeutic relationship.

An example of how I used these concepts can be seen in the therapy undertaken with Mr. Derby. He initially attended due to feeling under stress and experiencing relationship difficulties. He reported feeling ambivalent about his marriage, wanting to end the relationship due to feeling criticised and controlled but also feeling terrified of being alone, fearing that leaving the relationship would mean losing his sense of self. I would feel an intense rage from Mr. Derby, despite his outward behaviour seeming polite and obliging. However, at this point he would go blank or have a strong urge to run from the room. Mr. Derby described feeling judged or rejected by me, which made him feel resentful but, despite this, he continued to act in a charming and friendly manner towards me and would often express a concern for my welfare. After spending some time together it seemed that there were two ways that Mr. Derby related. One used his 'false self' (Winnicott, 1960), which he seemed to have developed in order to avoid conflict and conceal difficult emotions that he had repressed in his childhood. The other was his 'true self', which seemed to exist more on an unconscious level, which contained all of these emotions, which he had protected others from. We used Winnicott’s ideas to explore how he had learnt to repress his own needs and accommodate others because of his fear that his 'true self' was destructive. As a child he had felt rejected by his father and feared that his anger towards him had caused his death. Thus, he was afraid of expressing such emotions, meaning that they could only be expressed on an unconscious level. This enabled us to reflect upon how Mr. Derby would use this accommodating style to mask his strong negative emotions. We were then able to reflect on how this affected all of his relationships. For Mr. Derby this opened up an awareness of the feelings that he had
been desperately trying to avoid and thus consider how such suppression had been affecting his life, enabling him to experiment with new ways of relating.

Placement

This year was spent working in a student-counselling centre, with a psychodynamic supervisor. This held its own challenges because of the dual roles involved, i.e., being a student and working with students. This meant that I had to stay aware of issues of boundaries, so as to avoid over-identification. I valued the chance to work as part of a team and the opportunities it provided. The supervisory relationship was both containing and challenging, which facilitated reflection on process issues. The context had its own implications, i.e., clients came in the door without referral, which meant that it gave the client and I the opportunity to construct meaning regarding their issues, rather than this having been previously prescribed. I saw a variety of undergraduate and postgraduate students with a variety of issues; for example, marital problems, anxiety, trauma, academic issues, eating problems, and sexual issues. Issues of identity and self-worth were prevalent, which may reflect the life-stage that many students are going through, but it is also something that I feel is important to attend to in any therapy.

This year further highlighted to me the importance of integrating different therapeutic ideas and approaches. For example, I worked with Miss Ashford who was in her final year and attended because she was finding it hard to cope. Much of the work we did at this point was concentrating on her sense of self-worth and looking at her anxieties about being able to cope in the world after graduation. She had repeatedly been in relationships where she was dominated. Much of our work looked at her relationships and her feelings of ambivalence towards others because of feeling dependent yet resentful. Although I used some psychodynamic theory to conceptualise this work (Winnicott, 1960) I also relied heavily upon humanistic ideas. This allowed me to support Miss. Ashford in finding her own sense of self, whereas a more traditionally psychodynamic method may have repeated the pattern of power imbalance. However, in Miss Ashford's case, as with others, I came to realise that some practical cognitive
techniques would be helpful in order to provide her with new ways of asserting herself and coping with academic pressure.

This year enabled me to see the importance of being open about the process of therapy and have a dialogue with clients about assumptions regarding therapy. Negotiating the nature of the work undertaken together and identifying our different perspectives both helped to address the power imbalance in the relationship. For example, I worked with Miss Deugh who wanted help with the pressures of postgraduate life. As she came from south-east Asia and practiced an eastern religion she had differing priorities and perspectives to my western views. We addressed this by being explicit about our different perspectives and tried to find a place to meet in the middle. Several of the clients I saw this year were overseas students and, thus, many political, cultural and social issues had to be incorporated into the work, which reinforced the importance of social context to me.

**Research and personal therapy**

A psychodynamic approach makes more use of the therapeutic relationship, which in many ways made it a more intense year for me personally because it required a greater reflection on my use of self. Therefore, I used my own therapy (which was also psychodynamic) to reflect on counter-transference, i.e., how my reactions to clients stemmed from my own issues, as well as theirs. For example, when working with a student who had just been diagnosed with a disability I had to ensure that I was aware of the difference between his reactions and my own reactions to my disability. Also, as I shared the experience of being a student under academic pressure with my clients, I had to ensure that I did not blur boundaries. Such issues highlighted the importance of self-awareness and a combination of personal therapy and participation in an experiential group and enabled me to reflect on my perceptions of self and other.

The research I undertook continued to explore disability issues. I used the 'voice relational method, which held my presence and assumptions as a researcher as central. This meant that I had to be as aware as possible of what these assumptions were. This qualitative method felt congruent with my beliefs, as well as helping to develop my
awareness of how I interact with others and how my interactions are biased by my own perceptions. It also deepened my insight regarding how I understood, interacted and communicated about my disability, as well as how it influences my sense of self. This included the issue that I would not be aware if a client saw me outside of a therapy session, which has implications for myself and the client.

The third year

Theory

This year focused upon cognitive behavioural therapy (CBT) and, for me, also entailed an increasing focus upon developing an integrative style of working. Cognitive therapy is based on the principle that our thoughts have a profound impact upon our emotions, behaviours and physiology (Gilbert, 2000). Therefore, in its simplest form, cognitive therapy is based on identifying and changing problematic thinking patterns, beliefs or schemas (Beck, 1979). I found many of the CBT techniques useful in helping to define and work through clients' issues. This, at times, felt incongruent with my personal style, as it demanded a more directive and pedagogical role. Also, the perception that an individual's problems stem from how they interpret the world (Beck, 1979) seems overly individualistic, minimising relationship, contextual or systemic issues (Frank, 2002). Also, the underlying epistemological stance (i.e. rationality, empiricism, etc.) does not easily sit with my more constructionist perspective and places all of the knowledge with the therapist. Therefore, although I have found some of these more practical and active techniques helpful, I feel it would be more congruent if they were used as part of a more relational way of working.

This year also meant facing the issue of evidence-based practice, which is not a straightforward topic for me because of my views about knowledge and power relations (Foucault, 1988). This issue was foregrounded because CBT is based on technique and protocol, thus is easily evaluated using quantitative methods. This fits well into the Department of Health's assertion that therapy needs to prove itself
effective through such research in order to be valid. This is often based on positivist, empirical research; this concerns me as it does not easily fit with practice-based evidence. That is, I believe that the client's experience of therapy should be primary, rather than what 'should' be most effective according to standardised research. However, an emphasis on evidence-based practice is a reality within counselling psychology. I feel it is important to continue researching what good therapy is, as well as experimenting with new therapeutic approaches. Therefore, I need to clarify for myself how I can participate in the collection of such evidence in a way that is congruent for me.

Placement

I worked in an outpatient clinic based in a hospital during this year, which allowed me to gain awareness regarding how institutional and governmental factors can impact upon therapeutic work. For example, the number of clients a therapist is expected to see, who is allowed access to certain services, etc. I worked as part of a chronic reoccurring depression clinic and an obsessive-compulsive disorder clinic. I was encouraged to use standardised protocol, which was empirically tested and supported. This meant that I was often working in a cognitive way, integrating a more relational focus, whereas I would prefer it to be the other way around. In negotiation with my supervisor I strove to be flexible, as shown in the work undertaken with Mrs. Paxton who was referred due to depression. It was not appropriate to adhere to a rigid CBT structure of agenda-setting and homework tasks, as there was too much going on in her life at that time. Therefore, we negotiated that a more supportive style of therapy would be beneficial, providing her with a safe space in which she could express her emotions. This meant that she brought to the session whatever she felt she needed to attend to that week. However, I still held in mind a cognitive conceptualisation, as well as adopting a more humanistic approach. Thus, we were able to use some cognitive strategies to explore her negative thoughts and core beliefs (Greenburger and Padesky, 1995) which were making it harder for her to make any changes.
As my work continued and I gained confidence I began to integrate aspects of
different approaches into my therapeutic work in order to adapt to the individual
needs of each client, listening on multiple levels. That is, using a client-led approach
to ensure that I listened to the client's perspective on their experiences, using
psychodynamic ideas to help me listen for any transferential or unconscious material,
whilst working cognitively in order to identify any problematic cognitions or beliefs
and to use problem-solving to facilitate change. An example of this was when I
worked with Mrs. Huesdon who was referred for help with her depression. We used
cognitive techniques to identify some of her problematic ways of interpreting. This
enabled us to identify, challenge and find alternatives for her problematic patterns of
thinking that seemed to contribute to lowered mood and thus to depressed episodes.
However, in addition, I adopted a more humanistic approach to consider with Mrs.
Huesdon how some of her beliefs may be effecting how she relates to others, and to
ensure that she had an opportunity to address what was concerning her at this time.
This led to us thinking about her sense of self, what it meant to be a woman, a mother,
a daughter and a wife. This allowed us to look at how her past had contributed to her
belief that she must be 'perfect' for others and how this meant overlooking her own
needs. We used issues of transference to reflect on how this was being replayed in the
session by her striving to be the 'perfect client' for me. Finally, CBT techniques
allowed us to find ways Mrs. Huesdon could challenge her thoughts and beliefs about
herself and put into practice new ways of behaving that allowed her to act on these.

Research and personal therapy

This year I did not undertake my own therapy due to financial and time restraints.
However this, combined with a different style of supervision, highlighted how
important it is for me to be able to reflect on process issues. The research this year,
although still focusing on issues of disability, used a quantitative method. This
brought up similar issues to my reservations about quantitative evidence-based
practice. It felt over-reductionist and incongruent with my focus on subjective
meaning and experiential knowledge. However, I decided it would be a beneficial
experience for me to undertake such research, as it would help me explore which of
my assertions about such research are legitimate and which are not. Furthermore, it will help me to assess other research, which I am bound to encounter in my work.

**Conclusion**

I feel that at this point in my development as a counselling psychologist I am using a similar framework to that described by Newcross and Goldfried (1993). They integrate using a theory of therapy practice. This includes; assessment, therapeutic contract, a working alliance, generic and specific therapeutic skills and interventions, the therapeutic relationship, personal awareness, social and organisational context, theoretical understanding and the application of relevant professional ethical codes. This provides a base from which to develop in order to incorporate my worldview, new theoretical understanding and new experiences in clinical work. When looking to this task I am drawn towards two main ideas. The first stems from Clarkson's (1995) suggestion that the therapeutic relationship can be used as an integrative framework. Clarkson suggests that the work of therapy lies in the creative space between the client and the therapist; "the relationship seemed to me to be the factor that was vivid and obvious as the substructure on which most psychotherapies find their being." (Clarkson, 1995; p viii). Clarkson asserts that there are five types of relationship, i.e., the working alliance (enabling therapist and client to work together collaboratively), the transference/counter-transference (unconscious wishes or fears transferred onto the therapy), the reparative/developmentally needed relationship (a corrective, reparative therapeutic relationship which addresses a past insufficient, abusive or overprotective relationship), the person-to-person relationship (the 'real' or core relationship) and the transpersonal relationship (a spiritual dimension to the healing relationship). These are not stages, but different aspects of the work, which often overlap and can be used to incorporate different approaches into an integrative way of working. It is not offered as a new static theory, but as a way to keep exploring and evolving according to a client's needs. I am unsure if integration will ever become a static phenomenon in my work; instead, I will continue to integrate different ideas and practices throughout my career and life. This is in keeping with Clarkson's assertion that there is a "multiplicity of narratives about the human psyche and the healing
relationship" (Clarkson, 1995; p. xiv) and that we should not privilege any one particular view. Such a stance enables continued exploration of how different truths are constructed, without having to give one dominance. Thus, the belief that each interaction is unique can be used when working therapeutically to attend to the client's phenomenology as well as to consider the changing impact of context and power relations.

Another potential framework that would seem to provide me with a way to move forward is the use of an existential phenomenological approach as an integrative framework, as suggested by Milton, Charles, Judd, O'Brien, Tipney and Turner (2002). They suggest that the existential phenomenological approach to therapy can provide a framework in which to consider issues of epistemology and the overarching principles of what it is to be human. This approach asserts the importance of being in the world in an authentic way. It would enable me to address issues concerning how meaning is constructed, and when used to underpin therapy it looks at how we shape our reality by how we interpret life, others, the world and ourselves (Spinelli, 1999). Thus, meaning is derived from a client's frame of reference rather than from the therapist's interpretative framework. This approach holds the relationship as central, seeing it as the vessel through which therapy takes place, as well as being used to examine what being in a relationship may mean for the therapist and the client.

Therefore, in summary, I believe that attention to the therapeutic relationship, in all its forms, is essential to any therapeutic work and often is the core of the work. This does not mean that I do not also believe in the importance of theoretical knowledge and expertise. However, I agree with Norcross and Goldfried's (1993) assertion that the 'shoulds' of any one approach can get in the way of attending to what the client needs. Such eclecticism and flexibility needs to be balanced with being ethical and accountable for my work. An important aspect of this is being aware of the implications of my actions as a therapist and attending to reflective practice, as well as acknowledging difference in understanding between myself, clients and other professionals. I feel I leave the training with a well-stocked toolbox. However, I also feel that I have a lot to learn about how best to use the tools I have, as well as learning
some new tools in order to develop my ability to be helpful to clients and grow in my competence as a counselling psychologist.
References


RESEARCH DOSSIER
The Construction of People with Disabilities within Psychological Literature 1999-2001

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Abstract

This literature review considers psychological research pertaining to issues relating to disability between 1999 and 2001. It reviews the work included on the database ‘psycINFO’ and literature concerning physical impairments was focused upon. A material discursive stance was adopted in order to explore what representations and expectations were embedded in the literature. Also some of the implications these may have for future perspectives and research with disabled people as well as for Psychology more broadly were considered. The literature was organised into broad themes concerning, personal and mental attributes (including affect and identity), quality of life (including sexuality and reproduction, and discrimination) and therapy. Each of these was considered, from a social model perspective which informed a consideration of how the literature has constructed and/or perpetuated certain representations of disabled people. It concluded that disability is still perceived as a largely negative phenomenon within the psychological literature. Furthermore ‘the disabled’ are treated as a homogeneous group, sharing traits and experiences. Some of the implications for future research, as well as for counselling psychologists’ practice and training were also considered.
Biographical Details

I am a twenty-five year old disabled person. I have a degenerative eye condition which means I have been registered blind since the age of twenty-one. This research was undertaken as part of my doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. I chose to train as a Counselling Psychologist as its epistemological stance encourages a critical exploration of traditional psychological practice, whilst also allowing me to practice as a therapist. My keen interest in the Disability Movement led me to investigate what representations of disability are imbedded in Psychological research. Therefore this literature review aimed to consider what representations of disability were being constructed and perpetuated within the literature.
**The Construction of People with Disabilities within Psychological Literature 1999-2001**

**Introduction**

Physical impairment seems to have always been part of human existence. Archaeologists find in the oldest of remains, evidence that humans incurred severe, deforming injuries and still went on to live for many years. At some point this physicality took on a social meaning, a status and a stigma. As far back as the Bible, physical impairment was given a negative meaning, (e.g. John 9 vv1-12). Thus disability seems to have become a negative social phenomenon. Shakespeare (1993) feels it is important to differentiate between physical impairment and disability. He sees that the former comprises the embodied restrictions of a certain physical state and the latter is the consequence of a society that categorises the former into a socially devalued and disempowered position.

This paper aims to explore some of the representations of ‘disability’ currently prevalent in the field of psychology. By considering contemporary psychological literature from a social constructionist perspective, it is hoped to gain some insight into the assumptions and implications that are implicit to the representations of the disabled community. This may illuminate what representations inform contemporary psychological thinking and research regarding people with disabilities. The implications this may have for the maintenance of the current social position inhabited by disabled people will be considered.

In order to explore the beliefs embedded in the literature it is necessary to contextualise the review. Therefore a brief overview of how disability has been conceptualised will follow. This is in no way comprehensive but aims to set the scene and provide an historical background by which to navigate through current thinking. Coyle and Kitzinger (*in press*) contend that without an historical analysis psychological literature risks being individualised and decontextualised, foregoing an
enriched, comprehensive analysis. This will be followed by an examination of the current literature, organised into themes in order to identify what beliefs, implications and assumptions are inherent to it, bearing in mind the implications these will have for the training of counselling psychologists.

Historical Overview

Over the last hundred years western society has conceptualised disability in medical terms (Barton, 1996). It has been suggested that the industrial revolution promoted individualism, which changed social relations (Burman, 1994) excluding disabled people from the newly formed work force (Oliver, 1998). Therefore something had to be done with ‘the disabled’ and they became the responsibility of the medical profession. Oliver (1998) asserts that this led to disabled people being seen as sick and as needing a cure. As disability was likely to be untreatable in the conventional sense, disabled people came to be seen as tragic and lesser than those who can recover from illness (French Gilson and Depoy, 2000). Therefore, the medical model built a rehabilitation trade focussing on the monitoring and treatment of the individual (Oliver, 1996).

Developmental psychology evolved in the late nineteenth century and participated in the development of tools of mental measurement, classification of abilities and the establishment of norms (Burman, 1994). By spending its energies focussing on what was ‘normal’, it highlighted what was ‘abnormal’. Burman (1994) feels that inherent to this was a judgement of an individual’s ‘mental and moral qualities’. She feels this approach underpinned psychological research, supporting the notion that the abnormal (including the disabled) should be trained, segregated or sterilised (Pintner, 1933). Wright (1960) wrote about the view of the disabled integral to psychology at this time. He suggests that disability was regarded as a punishment for sin, contagious, and indicative of being helpless and economically inferior, and that any positive characteristics, such as being artistic, were an attempt to compensate for this.

Parsons (1952) suggests that recovery from disability was seen as beyond the power of the individual and thus required intervention, which maintained disabled people in
a dependant position. It has been suggested that this negative view, reinforced by charities, became a common sense view of 'the disabled' (Drake, 1996). This led psychology to focus on the guilt and shame associated with such a tragedy (Lindemann, 1981) and its presumed outcomes, e.g. maladaptive personalities and behaviours (Hersen and Van Hasselt, 1990).

However, a new way of thinking about people with disabilities emerged, re-conceptualising disabled people as an oppressed group (Barker, 1948; Chesler, 1965; Handel, 1960). In the 1960's a series of essays was written by disabled people offering a new perspective and giving a voice to empowerment movements, such as the Union of Physically Impaired Against Segregation. This led to new theorising and the publication of the Journal of Disability, Handicap and Society in 1986. Integral to this was the identification of a social model of disability. This asserts that the disabling effects of certain physical states stem from a disability hostile environment, in which social barriers inhibit personal choice (Gleeson, 1997). It sees that this is done through limiting physical access and access to information and resources to disabled people. This conceptualises disability as diversity within the human condition, rather than an illness to be cured. Questions were starting to be asked about the nature and practice of previous psychological research and Oliver (1996) suggested that disabled people needed to move from being passive subjects to active participants.

Simultaneously, Barnes (1991) introduced the idea of institutional discrimination asserting the need for anti-discrimination legislation. The passing of the Disability Discrimination Act in 1995 seemed to signal an acknowledgment that disabled people as a community are discriminated against. However, before this the Act was turned down 13 times largely for economic reasons. Paradoxically supporters of the Act were criticised by disabled empowerment groups because many of them were seen to perpetuate a state of oppression through agencies for control, e.g. residential homes (Barnes and Oliver, 1995). It was suggested that these keep disabled people segregated from society and maintained in a monitored, dependent environment. It was also contended that the government failed to acknowledge indirect discrimination, and that the Act was ambiguous and difficult to enforce.
The British Psychological Society (BPS) currently uses a medical model to conceptualise disability, maintaining that, ‘disabilities occur because of physical impairments which have resulted from the underlying disease or disorder’ (p205; Johnston, 1996). The dominant model used is that of the World Health Organisation, which defines people with disability in terms of performance deficits. This model implies that disability can be overcome by recovery from a physical disorder (Johnston, 1996).

**The Search**

Whilst considering the history of disabled people it became apparent that disability has been represented as a negative, largely tragic phenomenon, still generally conceptualised in medical terms by the psychological profession. As a registered blind woman myself, I found these perceptions problematic and the literature did not reflect my own experiences or self perceptions. Time and time again I came across the phrase ‘disabled people’ without being certain exactly who that meant and certainly not identifying with the associated characteristics. Therefore I decided that I wanted to look at what assumptions and implications lay beneath the current psychological research regarding disabled people.

I decided to do a literature search using the online database ‘psycINFO’, which enabled me to look for any published psychological research concerning disability. I was originally interested in any recent information pertaining to disability; however this involved an overwhelming amount of information. Therefore, I decided to omit learning disabilities as I feel this is a complex matter, partly due to the added stigma it seems to receive in our society and partly due to the complexity and diversity it adds to an already over homogenised group. I concentrated on the last three years of research in order to consider contemporary representations. Therefore the parameters for the search were ‘1999-2001’ and ‘physical disability’ (see appendix A).
Theoretical Stance

The literature will be considered from a position of material discourse, as outlined by Lucy Yardley (1997). This considers the physical features of human life whilst holding discourse as central, emphasising the socially and linguistically negotiated nature of human experience. This stance seems to facilitate an exploration of the construction of disability as it considers the physical constraints and potentialities of our existence whilst holding in mind how the social environment affects this (Berger and Luckman, 1966).

Rather than seeing an 'objective reality', material discourse considers how our reality, including that portrayed by scientists, is shaped by the purposes, conventions, aspirations and assumptions intrinsic to human life. A material discursive stance does not disregard scientific analysis, but emphasises that medical and psychological assertions are not simple facts. Rather it considers the contextual nature of truth, influenced by time and place. Thus it sees how reality is constantly shaped and reshaped by the perceptions, intentions and activities of the members of society (Yardley, 1997). Similarly, a material discursive perspective does not deny that the material dimension for living organisms is an objective realm of physical matter and mechanical process, but sees that it is embedded with purpose and continuously changing through dynamic interaction with the environment (Yardley, 1997). Therefore ecology, i.e. the relationship between an organism and its environment, is a central consideration.

Fundamental to this is a consideration of how the socio-linguistic aspects of our experience relate to our material existence. Traditionally it was considered that words stem from the reality that they describe. However social constructionists postulate that words gain meaning through context and mutuality (Gergen, 1985; Potter and Wetherell, 1987). Thus meaning is not fixed but ambiguous, with language being functional rather than descriptive (Harré, 1991). This opens up a consideration of how ideology and power relations are embedded and perpetuated in our systems of linguistic meaning and social organisation (Foucault, 1988).
Yardley (1997) argues that Western society conceptualises the individual as bounded and autonomous, which allows the responsibility for any illness or disability to be conceptualised as a facet of the individual. Discursive theory states that instead, the identity, behaviour and expressed beliefs of individuals are largely due to their cultural history and social position (Yardley, 1997).

Yardley’s approach provides a way of studying the embodied meaning of health and illness in context, and considers how bodily states change our perceptions of the environment. However, it also sees that the social and physical environment endows our bodies with meaning. Merleau-Ponty (1962) sees that we communicate through and are given social standing by our bodies. Therefore a phenomenological stance considering the subjective experience of inhabiting such bodies is necessary to explore alternative perspectives. Thus the stance taken here aims to combine ecological, phenomenological and discursive stances. Through combining an awareness of the meaningful character of material being with a recognition of discourse and environment, it is hoped to gain a deeper understanding of how disability is positioned within current psychology.

Terminology

A brief consideration of the terminology used throughout the literature will be offered here as it is indicative of certain representations. The most common term used in the literature was ‘physical disability’. Often the term was not defined and no explanation was given of what physical impairments it included. Some papers were very specific as to the type of physical impairment they dealt with, e.g. haemophilia (Bell and Stoneman, 2000). However, such specific terms were often used interchangeably with the terms ‘physical disability’ and ‘disability’, without acknowledging that these terms may also refer to a plethora of other physical states. These terms were used without any exploration of who they actually described or what the implications of such labels are. This seems to homogenise a potentially diverse group, overlooking the differing experiences which may accompany particular physical states; also it does not make room for a consideration of different social and environmental contexts. For example, a person with multiple sclerosis who lives in a residential home may have a
very different experience of life to a partially sighted woman living independently. I will use the terms 'physical impairment' and 'disability' in order to differentiate between the physical and social aspects of disability (Shakespeare, 1993). I will also use the term 'disabled people' in order to recognise a cultural identity stemming from societal oppression rather than 'people with disabilities' which seems to individualise disability. However, I do not make any assumptions about experiences, physical states, identity, lifestyle or situation.

**Personal and Mental Attributes**

The thematic organisation of the papers led to some broad areas of research being identified. The first area considered how personal and mental attributes were linked to factors affecting disability. This included research covering affect and identity, which will be considered in order to explore representations integral to the work.

**Affect**

There seemed to be an emphasis on the role that negative emotions play in the psychology of disabled people and how this may affect the way in which they experience their physical impairment. Depression was commonly associated with physical impairment (Ormel, Vonkorffoldehinkel, Tiemens, and Uestuen, 1999) and Abberley (1987) sees that such negative associations have given disabled people a detrimental status and this representation may reflect an historical bias.

Dennis, O'Rourke, Lewis, Sharpe and Warlow (2000) explored the link between affect and disability by considering how emotional distress rather than physiology affects a person's level of disability. This seems to move towards an assumption that disability in part relies on an individual's emotional and cognitive characteristics. There seems to be a presumption that levels of impairment are intrinsically linked to the individual's subjective qualities. Thus they feel that information is needed concerning factors that may contribute to emotional distress in order to identify those at greatest risk. They recommend that interventions are needed (e.g. anti-depressants) in order to change aspects of the individual. Such research maintains a traditional
focus on the individual as deficient, which minimises the need for change on an institutional or social level. The study constructs stroke patients as being prone to emotional problems and links this to outcome after a stroke. They measured mood in 372 stroke patients using self-rated questionnaires complemented by information from medical professionals. The participants seem to be placed as passive subjects by the scientific discourse underpinning the research, indicated by the fact that a medical professional assesses their mood on their behalf. Dennis et al. (2000) claim a link exists between severity of stroke and depression (as measured by the Hospital Anxiety and Depression scale - HAD) and recommend that future studies may need to examine factors such as emotional support, treatment and socio-economic variables. However, this study does not consider any contextual or societal factors affecting a participant’s emotional state, level of disability or impairment.

There was also an assertion that a disabled person’s own perspective had an effect on the level of impairment they experienced. For example, Hansen, Fink, Frydenburg, Oxhoj, Sondergaard and Erikson (2001) see that the severity of an individual’s impairment is linked to their mental state. Hommel, Chaney, Mullins, Palmer, Wees and Klein (2000) investigate on what basis a person rates their level of ability using the Activities of Daily Living indices, suggesting that psychological factors are as integral to disability as physical factors. They suggest that cognitive appraisal may affect the management of rheumatoid arthritis (RA). They aimed to investigate previous claims that cognitive distortions (e.g. catastrophising; Keefe, Lefebvre, Egert, and Afflect, 2000) are associated with depression, which in turn affects the severity of impairment. A physician’s assistant gave an objective rating of disability of 42 participants with RA, using the Modified Stanford Health Assessment Questionnaire, whilst participants completed the style of attribution questionnaire (SAQ). Hommel et al., (2000) contend that internal negative attributions (e.g. self blame) have beneficial effects particularly when leading to more adaptive responses in future situations. They see the attribution of negative events to one’s own modifiable behaviour enhances perception of control over and avoidance of future negative events. They maintain this gives a person an advantage by establishing a sense of control over negative disease events. However, this is done without considering a participant’s control over environment, or autonomy over their care.
The research reviewed associated individual characteristics such as self-efficacy (Orbell, Johnston, Rowley, Davey, and Espley, 2001), beliefs (Jenson and Romano, 2000) and goal orientation (Elliott, Uswate, Lewis, and Palmatier, 2000) with the level of impairment experienced. Landro, Sletvold and Celius (2000) also note that a person's subjective report of impairment is more closely linked to levels of depression than an objective one. Many recommend interventions to change the individual's way of behaving or thinking in order to facilitate improvement or rehabilitation (Dennis et al., 2000; Hommel et al., 2000; Huebner, Thomas and Berven, 1999; Jenson and Romano, 2000; Orbell et al., 2001). This is upheld by Llewellyn's (2001) assertion that physical impairment is the overriding factor in the psychological development of disabled children. However, Coyne and Kagee (2000) in their review, warn that if impairment or disability is misattributed to an individual's mental state it may lead to an inappropriate allocation of resources.

The research implies that the level of impairment experienced depends in part on the individual's attributes. Thus the responsibility for well-being, measured in terms of level of adjustment, is placed firmly within the individual without any consideration of environment or socio-historical context. This seems to reflect a stance that regards people as bounded autonomous individuals. The assertion that the ability to cope is improved by self-blame (Hommel et al., 2000) implies that disabled people need to take responsibility for negative outcomes. That is, little consideration seems to be given to how the status and representations of disability may play a part in the individual's experience or perceptions. This negates the medical professions (inclusive of counselling psychology) from taking responsibility for the negative societal position disabled people currently inhabit.

The literature reviewed does not take into consideration how the research or social context may affect the experience of being disabled. By placing the emphasis within the individual, it denies any consideration of social interactions. There is no acknowledgement of how power relations between disabled people and medical professionals may shape the experiences of disabled people. This could be seen to be evident in the language, context and research style inherent to psychology, which sees
the researcher as an objective observer. It may be suggested that the focus of research needs to concentrate less on the individual and more on the construction of their position and how this may affect their perceptions and experiences.

The papers reviewed seem to measure levels of impairment in terms of how ‘rehabilitated’ or ‘adjusted’ a disabled person becomes in quantitative terms (e.g. the SAQ). This involves placing the disabled person under a medical gaze assessing their qualities in isolation from their context. This collects information in a decontextualised, codified way and does not provide a forum for the inclusion of the participant’s subjective meaning, or for any inclusion of environmental or interactional variables. Some go further to reduce their participants to biological entities defining their emotional experiences only in terms of their physiology (Roca, Su, Elpern, Mcfarland, and Rubinow, 1999). There seems to be a sense of linear causality integral to the research, in line with traditional scientific stances. None of the research was based on a qualitative exploration of the experience of disability. This may reflect an overly reductionist treatment of a potentially rich source of personal experiences, whilst also overlooking a diversity of experience both within and between different types of physical states.

Thus the literature considered above seems to convey an image which implies that disabled people are a group that primarily displays negative affect and cognitive styles, which augment their levels of impairment. If it follows that research informs psychological and thus therapeutic theory and practice, then images constructed by the research may become integral to the views of professionals, inclusive of counselling psychologists. This in turn may become part of our society’s knowledge about disability and intrinsic to the identities of disabled people.

Identity

The literature reviewed considered identity and issues pertaining to it. Identity will be considered to pertain to how one constructs a sense of self through a dynamic process of interaction. For example Ellis-Hill and Horn (2000) saw that an individual’s self-concept was negatively affected following a stroke, as measured by the HAD scale,
the Frenchay Activity Index and the Head Injury Semantic Differential Scale. If such research informs health professionals, it may shape their perceptions, expectations, prognosis and thus the provision they make for disabled clients, which in turn may affect the group’s perceptions of themselves. This may be especially true if identity is seen to develop from the interaction between the biological organism and its social context (Breakwell, 1986). If the physical being is seen to contribute to the content of identity then the social meaning ascribed to the body is also central. This meaning is culturally and historically specific, ascribing value to certain states and characteristics. Thus the meaning given to a disabled body may affect the disabled person’s sense of self-worth.

The remaining work concerning identity seems to focus on forming a positive self-identity in order to facilitate positive change. Stewart and Bhagwanjee (1999) considered the promotion of group empowerment and self-reliance through participatory research. This sees how factors such as control over resources and the role of the health professionals affected perceptions of self-reliance and empowerment. Chambers (1999) and French Gilson and Depoy (2000) suggest that a broader consideration is needed. They contend that in order to facilitate positive change, disability needs to be conceptualised in terms of a cultural identity. They see that this would promote a consideration of the socio-historical context surrounding disability. It is suggested that a positive cultural identity can replace the traditional oppressive representation of disability. However, the assumption that a shift can be made in order for a disabled person to integrate their disability or physical impairment in a positive way needs some thoughtful consideration. Firstly, it demands that a person with a physical impairment takes on their disability as a dominant, if not primary identity. Secondly, it requires that this is positive and a catalyst to personal and political change, which seems to hold presumptions about the desires and experiences of disabled people. Furthermore, such a shift would require social and systemic changes and does not seem to take into account other cultural diversities.
Quality of Life

Another theme that was identified in the literature concerned issues pertaining to disabled people’s quality of life (QOL), which has been adopted by psychology as an outcome measure. Although often related to life satisfaction (Ferrans and Powers, 1985; Young and Longman, 1983) QOL remains poorly defined, varying in definition and measurement (Holmes, Coyle and Thomson 1997). The concept seems to lack coherence, relating to a diversity of well-being issues. QOL was treated as an area of interest in its own right within the literature, and included areas concerning sexuality and reproduction and discrimination. These areas will be discussed, considering what representations of and assumptions about disabled people are integral to them.

The work seemed to make a direct link between disability and QOL, suggesting a presumption that the former affects the latter. This literature seems to measure a person’s QOL in clinical terms, using specific physical (Wahl Mourn, Hanestad and Wilklund, 1999) or psychological traits (Koplas Gans, Wisley, Kuchibhatla, Cutson, Gold, Taylor, and Schenkman, 1999). These criteria, although achieving validity within a scientific discourse, may be over reductionist concerning such a potentially complex and diverse area as QOL. The research reviewed does not make space for the participants to contribute to the definition of QOL, and thus seems to neglect any phenomenological exploration. The methodology and thus epistemology underpinning this work on QOL invokes the same critique as voiced in the ‘affect’ section of ‘personal and mental attributes’ (page 8).

Murrell, Kenealy, Beaumont, and Lintern (1999) consider the approach taken when measuring QOL, aiming to assess the validity of measures (i.e. the SF-36 and the Schedule for the Evaluation of Individual QOL). Although both are psychometric measures, the former is health based whilst the latter is person centred. It was found that the health based measure was more reliable by traditional re-test standards, although the person centred measure was more sensitive to life changes or daily QOL. This raises the issue that although some psychometric measures may test very well in terms prescribed by a traditional scientific discourse, i.e. validity and reliability, they do not necessarily give an indication of the subjective experience of participants’
lives. A measure designed for and thus testable by a certain epistemology can only prove itself within that discourse. Furthermore, these psychometric tests do not provide insight into the long term effects of certain physical states over time, which a qualitative phenomenological approach may facilitate (Holmes et al., 1997).

Meyers (2000) asserts that research on QOL displays an historical bias, focusing on the destructive nature of disablement. He feels measures are needed that relate to health satisfaction and QOL, which make a consideration of positive affect. He contends that even people with the most notable impairment show high levels of happiness. However this paper does not take into consideration how certain representations or environments may cause or affect disability. It is encouraging to see a paper challenging the negativity associated with disability; however it still maintains an individualistic, quantitative basis. It may be suggested that the best way to elicit the positive benefits of diverse physical states is by exploring personal accounts through a qualitative approach.

**Sexuality and Reproduction**

Sexuality has been included in psychological measures of QOL, such as the WHOQOL which has been developed collaboratively by the psychological community (WHOQOL Group, 1998). It aims to assess individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (WHOQOL Group, 1995). When using a focus group to establish facets of QOL, issues of sexuality, body image and sexual activity were found to be significant, and as a result were included in the national and international WHOQOL (Skevington, MacArthur and Sommerset, 1997).

However, sexuality seems to have been omitted from the representations of disabled bodies and thus estranged from the identities of disabled people. It has been suggested that disabled people are treated in an asexual way by their parents and health care workers (Hallum, 1995) and that this is fuelled by the belief that disabled people are incapable of having or being interested in sex.
Berman, Harris, Enright, Gilpin, Cathers and Bukovy (1999) Sexuality and the adolescent with a physical disability: et al., (1999) examined the areas of sexual knowledge, sexual behaviour and beliefs about sexuality among adolescents with congenital physical disabilities. They felt that the lack of research in this field was disturbing as sexuality is a central concern of adolescents and their families and because its absence in the literature reinforces the myth that disabled people are not sexual. They found that generally adolescents with physical impairments are uninformed or misinformed about general sexual knowledge and how it relates to their impairment. The Sexual Knowledge Interview Schedule was used and although this asks open ended questions, answers are codified and interpreted within a scientific discourse. Therefore answers that lay outside that which is considered 'normal' by the medical professionals may be overlooked, excluded or seen as an exception to their rule and dismissed as abnormal.

Further to this, Berman et al. (1999) developed a relationship questionnaire in order to elicit the participants' understanding of the impact of their impairment and disability on their sexuality. This seems to uphold an assumption that disability will affect a person's sexuality. However as disabled people experience a diverse range of physical states it seems just as likely that impairment would have no impact. Berman et al. (1999) suggest that a disabled person's sexuality will be affected by the expectations and perceptions of society. Nevertheless, the work does not consider that a young person's familial stance on sexuality or their general level of knowledge may affect their sexual knowledge independent of their disability. Also, the presence of a 'potential for abuse' sub-scale, seems to reinforce the representation of disabled people as vulnerable. Berman et al. (1999) see that in order to develop disabled people's awareness, medical professionals need to provide information; however this may sustain certain power relations. The implication seems to be that a disabled person can only explore their sexuality by being informed and facilitated by others, rather than by a natural autonomous exploration, which seems to be presumed of non-disabled adolescents. Despite the paper's desire to counteract traditional views of disabled people's sexuality, the publication of work that considers what disabled people do not know, or do not do, may serve to maintain historical stereotypes.
To assert that disabled people are sexually oppressed does not deny that certain bodily states may affect sexual practice. The paper by Collins (1999) considers the restrictions which may be experienced by some women with particular physical impairments and asserts the need for women to have choice concerning their reproductivity. She highlights the paradox that women with physical disabilities are being denied equal access to reproductive technologies, whilst being defined and threatened by them. The paper sees that many disabled woman will have pregnancy - usually a private domain - publicly controlled for them. However, such research dealing with sexual oppression should acknowledge that some physical impairments may have a profound affect on women’s ability to conceive or carry a child, whilst avoiding a presumption that this is problematic for all disabled women. Also it should be clarified that physical restrictions are quite different from social ones. Furthermore there should not be a presumption that such physical limitations are detrimental to sexual identity or sexual desires. There also seems to be a focus on heterosexual disabled men and women, which seems to further marginalise gay men, lesbians and bisexuals within the disabled community. This again feels as though the homogenised perception of the ‘disabled’ is minimising a diversity of experience. There may be many disabled people whose biggest barrier to sexuality is the presumption that there should be a problem.

The paper by Bell and Stoneman (2000) may reflect a more sinister reason why sexuality is not associated with disabled people; that is, the idea that the number of disabled people should not increase through procreation. They found that there was an increased likelihood of aborting a foetus with a physical impairment, due to a negative association with disability. They found that parents did not want to give birth to a child with physical impairments such as Downs Syndrome, spina bifida and haemophilia. This would seem to reflect the attitude that Swain and French (2000) suggest underlies Western culture, that is, ‘you are better dead than disabled’. This can be seen in the abortion laws which allow a foetus to be terminated at any stage of the pregnancy if it is shown to have impairment. The research found that even women who are against abortion in principle will have prenatal testing to screen for impairment and would have an abortion if it is found (Kyle, Cummins and Evans 1988). The fact that this topic is researched seems to imply that the medical
profession facilitates the prevention of disabled babies being born and that this is a common and acceptable practice.

**Discrimination**

Issues of discrimination may have far reaching implications for the lives of disabled people. However the field has been considered to be less developed than work done pertaining to sexual orientation, race or gender (Abberley, 1987). There were only three papers in the literature reviewed that dealt with discrimination in a direct way and all three related to employment. It could be argued that this reflects a desire to make disabled people productive in economic terms in line with capitalist ideology integral to western societies.

Stevenage and McKay (1999) considered how attractiveness affects discriminatory attitudes. They found that those with facial disfigurement and to a lesser extent physical impairment are more likely to be attributed with negative characteristics and thus less likely to be employed. However this does not consider the socio-historical factors that may mediate the perceptions and representations integral to an interaction such as a job interview. Furthermore it does not explore the assumption that disabled people are unattractive, which may be related to the notion of disabled people being ‘nonsexual’. If such underlying assumptions are not brought into the debate on discrimination, the language and presumptions of employers and social institutions more generally may not be questioned, stifling change.

The paper by Koser, Matsuyama, and Koelman (1999) considers whether employers are less likely to hire a mentally impaired job applicant than a physically impaired one. This found that someone in a wheelchair was more likely to be hired than someone taking medication for depression and anxiety. However this was done by sending a written profile to potential employers rather than in a face to face encounter. Therefore this may not reflect disabled people’s subjective experiences of discrimination. Firstly the visible nature of a wheelchair means a person has little choice in disclosing their disability as opposed to a person who has no visible signs. Secondly it does not consider the way that understanding and perception are
constructed between people; that is, in meeting face to face, the context and specifics
of that interaction may affect the decisions and perceptions held by those people in a
way that cannot be replicated in the written word. Again this highlights the problem
of trying to codify or make abstract affairs that are primarily concerned with daily
interactions and perceptions.

The third paper, by Perry, Hendricks and Broadbent (2000) investigated access
discrimination (e.g. inaccessibility to buildings) experienced by disabled people in
comparison with non-disabled people. This considers access discrimination as central
to an employee’s experience of discrimination, without highlighting that this is
specific to a particular group of disabled people, i.e. the mobility impaired. The lack
of specificity regarding physical states highlights the presumed yet undefined
distinction between disabled people and non-disabled people found throughout the
literature. This dichotomous view of disabled people, in opposition to non-disabled
people, is made particularly apparent by the occurrence of several papers that consider
how disabled people affected non-disabled people, or how non-disabled people
perceived disabled people (Beck, Fritz, Keller and Dennis., 2000; Bode, Weidnener
and Storck, 2000; Dalal and Pande, 1999; Findler, 2000; Harper, 1999; Mukherjee,
Lightfoot and Sloper, 2000; Roberts and Smith, 1999; Weiserbs and Gottlieb, 2000).
The general consensus throughout this research was that disabled people were
perceived negatively by non-disabled people and are burdensome to their families and
teachers.

There seems to be an assumption implicit in the literature that a disability will lower a
person’s QOL. However paradoxically there does not seem to be a coherent
consensus within psychology as to what constitutes a good QOL. It seems that the
central concerns within the literature when considering the life of a disabled person
are how they affect others and what others can provide for them. There seemed little
consideration of what disabled people do for themselves and how this affects their
QOL, or how limitations put on disabled people’s autonomy or access may lower their
QOL. Furthermore the focus on the non-disabled may reflect how disabled people are
not recognised or listened to in their own right. This is further indicated by the fact
that disabled people’s own views on what constitutes a good QOL are not researched.
This in turn may highlight how disabled people’s own context, for example their culture, may mediate their experiences.

**Therapy**

The third theme that I will concentrate on considers how disability issues impact on the practice of therapy. This is an area of particular importance to me because I am a trainee counselling psychologist. Also, I feel that the way in which disability is dealt with by therapists, and in turn by institutions that train therapists, is of key importance because this shapes how disabled people are theorised about. Such theorising contributes to how disabled people are perceived and categorised, i.e. as deviant or abnormal (Burman, 1994). This will in turn impact upon societal representations of disability and therefore on the experiences of disabled people. It will be considered what the current literature implies about how disability is conceptualised within the therapeutic community.

The paper by Fuertes, Bartolomeo and Nichols (2001) looks at how counsellor multiculturalism competency impacts on the practice of therapy. This is an approach that recognises the existence of multiple belief systems and perspectives, asserting the need for counsellors to attend competently to the culture and context in which clients operate (Pope-Davis and Ottavi, 1994; Pope-Davis, Reynolds, Dings and Nielson, 1995). This includes three broad areas: 1) counsellors’ racial and cultural self awareness, inclusive of an understanding of cultural or racially based beliefs and attitudes about self and other; 2) counsellors’ understanding of the client’s world views, beliefs, cultural values and socio-political experiences and influences, with a view to how these may affect therapeutic practice; and 3) counsellors’ ability to use intervention strategies that are sensitive to the cultural and contextual factors of the client (Sue, Arredondo and Mcdavis, 1998).

Work done by Sue et al., (1992) further developed a conceptualisation of culture and difference, which included factors such as sexual orientation, disability and socio-economic status. However what is considered as a cultural identity is still not concretely defined amongst the psychological community. There has been an
assertion that disability itself is a cultural identity by those such as Abberley (1987), Chambers (1999), French Gilson and Depoy (2000), and Swain and French (2000). However this is not widely accepted within psychology; the British Psychological Society for example still conceptualises disability largely in medical terms (Johnston 1996). Therefore although a multicultural approach is potentially liberating, leading to a deeper understanding of the phenomenology of disabled people, ‘disability’ is not universally recognised as a cultural identity, either by psychology or by disabled people themselves. Also there may be a question as to whether a disabled therapist would be better suited to such an approach, although it should not be presumed that because a therapist is disabled that they will automatically have insight regarding the experiences of a disabled client. Furthermore a disabled client who does not embrace a disabled culture may not be able to gain from such an approach. Also care should be taken that a disabled cultural identity does not overshadow or conflict with any other cultural identities.

Fuertes et al., (2001) assert the importance of having the client as central to such work by using adapted instruments such as the Cross Cultural Counselling Inventory-Revised (CCCI-R; LaFromboise, Coleman, and Hernandez, 1991). This approach privileges a ‘scientific’ discourse, which implies an adherence to an empiricist bias. This may highlight the pressure that the therapies are under to conform to a scientist practitioner model in order to gain validation from the scientific community. Despite the possible limitations posed by a quantitative approach, this work seems mindful of specific differences within the populations measured, an aspect that seems to be lacking from much work done with disabled people. This is reassuring, as to conceptualise such a diversity of people in terms of a broad category such as culture, may over generalise. Further to this, it seems to have respect for the autonomy of its participants, which may also be overlooked in research with disabled people. Despite the bias towards ethnic or racial awareness it could enable counselling psychology to consider diverse physical states. It may be that future work is needed focussing more specifically on the advantages of such an approach for disabled people and on what constitutes a ‘disabled culture’.

The other two papers consider what impact a disabled therapist may have on
therapeutic practice. The first of these by Linton and Daugherty (1999) looks at perceived therapeutic qualities of disabled counsellor trainees. However the study acknowledges that using a video tape, rather than a face to face interview, may have affected its findings. They suggest that a client’s perception of the qualities of the counsellor - e.g. expertness, attractiveness and trustworthiness - determine how they value the counsellor’s interventions and thus experience therapeutic change. They explored whether disability status would affect such perceptions. Their postulation that a trainee presented as having a learning disability would be perceived as less favourable than a physically impaired or a non-disabled trainee, was not supported. They suggest that the negative association with the trainee status of the counsellors may have overridden the weaker negative association with disability (Mckee and Smouse, 1983). Also Lintem and Dougherty (1999) suggest that the fact that participants worked in a group may have affected how they chose to represent themselves, not wishing to appear discriminatory due to a pressure to be ‘politically correct’. There seems to be two considerations here; that is, a person’s reactions to ‘disability’, which may be obtained through a secondary source such as a video tape, and the perception based on a face to face encounter. The latter will have many complex variables which may affect a client’s perceptions of a therapist and it may be hard to untangle which of these is due to physical impairment. Also, there is no specificity regarding type of impairment or learning disability, which may affect clients’ perceptions and should be considered in future research (Bell and Stoneman, 2000).

The third paper considered the impact of a disabled psychiatrist within the field of psychotherapy. Chaudhuri (1999) considers the effect that a trainee psychotherapist may have on colleagues and clients. He feels that the effect of a disabled psychiatrist on the therapeutic alliance has never fully been explored. However this seems to perceive disability as ‘different’ rather than a diversity within physical states. It is not that disability should not be considered but rather that it should not be considered in opposition to ‘normality’. Chaudhuri (1999) sees that although personal contact and interaction are essential between non-disabled and disabled colleagues, this can be absent because of anxiety, leading to an avoidance reaction. Asch and Roussou (1985) see that a disabled psychiatrist’s psyche may be affected by others’ projections. It is
suggested that contact with disabled people stimulates a fear of losing one's own bodily integrity (Anisfeld, 1993; DeWald, 1982). Furthermore, Chaudhuri (1999) asserts that the disabled psychiatrist's narcissism may be injured because he or she needs a physical aid such as a wheelchair; he feels that this leads to internalised feelings of shame and guilt for having succumbed to an injury. It is postulated that the wheelchair becomes a sign of the psychiatrist's mortality and thus provokes fears about the mortality of those around him or her. However this does not consider that the symbolism and negative representations of disability may stem from a particular historical construction. This seems dangerous as it perpetuates historical prejudice using psychotherapeutic theory in a way that legitimates and continually constructs disabled people as different and intimidating. It seems to maintain a focus on how disability is dangerous to the psyche of the disabled person and those around them.

The paper suggests that disabled therapists have not been discussed within the profession, perhaps stemming from the fact that Freud himself never wrote about his struggle with cancer. It goes on to consider how the client may perceive the disabled body as indicative of cognitive or emotional problems, which may affect the therapeutic relationship. Chaudhuri (1999) also considers other factors that may affect this, such as the therapist's temperament. However literature reviewed earlier in this paper seems to presume that disability fundamentally affects such personal attributes. Chaudhuri (1999) goes on to say that an openness is needed by a therapist in order to explore perceptions of the therapist's impairment, but that this can be beneficial in its own right leading to an exploration of transference resistance. He sees that a consideration of such factors is important because although the profession confesses the importance of what the therapist brings to the therapy, he feels it is rarely given the same salience as a client's contributions. He feels although this should not turn into an exhibition of the therapist it is important to dispel any hidden fantasies about the disabled therapist. However no mention is made of exploring the origin of the fantasy and whether it reflects a social stereotype. Doing this may turn the therapeutic session into a re-education of the client which is not appropriate; however to overlook stereotypes and to perpetuate them does not seem responsible either. Furthermore the article concentrates on the visible nature of disability and the symbolism this holds, once again ignoring the diversity within the disabled community. Abend (1984)
discourages the disclosure of unseen disabilities as this may evoke guilt in the therapist because of their unconscious exhibitionist conflicts. Furthermore, traditional psychoanalytic literature suggests that congenital defects and childhood abnormalities may cause ego defects in aspiring trainees (Asch, 1985).

This approach seems to perpetuate the ‘otherness’ and ‘difference’ created by a traditional view of disability, without any cultural or historical context. This places the emphasis on the individual disabled therapeutic professional. However Chaudhuri (1999) goes on to give case examples and concludes that his disability has not had a negative impact on his therapeutic work. He feels that psychoanalysis needs to find a better understanding of disability, moving away from a purely negative concept of it as symbolic of death and castration anxiety. Nevertheless, he seems to legitimate the associated negativity in theoretical terms.

It seems that in a consideration of therapy consistent with the other therapy literature reviewed, a mixture of perspectives is evident; that is, there is still evidence of disability being perceived in negative terms and placed firmly within the individual therapist. There is only a tokenistic consideration of any advantages that may stem from a diversity of physical states and disability seems to be ascribed as a salient feature of the individual. Although there is a consideration of the culture of disability this is only considered in terms of how it is similar to other group identities.

**Summary**

The overview at the start of this paper identified two main ways of theorising about disability, stemming from either a medical, individualistic approach or newer social explanations. It seems that after considering contemporary psychological research undertaken regarding disabled people that the former underpins much of the current research. It seems as though disability is still perceived as a largely negative phenomenon, associated with negative affect, lowered quality of life, diminished sexuality, discrimination in the workplace and reduced competence in the practice of therapy. The overwhelming presumption underlying this work seems to be that disability is a visible physical status, mediated by an individual’s thoughts and
behaviours. Furthermore disabled people are treated as a homogeneous group, sharing traits and experiences although little or no consideration is given to who falls into that category, and how their experiences differ. The role of non-disabled people was considered, but not in terms of how their behaviours or beliefs may impact on the opportunities available to disabled people, but rather in terms of how they helped, or were hindered by disabled people.

There was evidence of a consideration of the constructed nature of disability, as apparent in ideas concerning a disabled culture, the emancipation of sexuality and a multicultural approach to therapy. However it feels as though the conditions needed to make space for such a reconceptualisation are constantly reduced by the impinging presence of traditional assumptions which still seem to be inherent to psychological research. The paradox is that psychological theory and in turn counselling psychology will not change without fresh perspectives provided by research. Furthermore without new theoretical ideas being voiced there will be no motivation to undertake such research. The answer may lie in a new way of researching which holds the experiences of disabled people as central and includes a diversity of perspectives. This seems to be best served by qualitative methods that can consider phenomenology and issues of social construction.

Counselling psychology could capitalise on its integrative nature, to utilise appropriate therapeutic orientations to facilitate a new emancipatory approach to research and therapeutic practice. Existing approaches from within the field of psychology could be utilized to provide a style of therapy more appropriate to disabled people. For example the client-centred approach may enable an exploration of disabled people's contexts and the meanings these have for them (Lenny, 1993). This could be combined with a multiculturalist approach in order to provide a consideration of issues of diversity within the individual (Sue, Arredondo and McDavis, 1992). Finally, an affirmative approach could be adopted as is used in affirmative lesbian and gay therapies (Milton, Coyle and Legg, 2002), in order to enable an exploration of issues of oppression and negative representations regarding disability. Such a combination of approaches, underpinned by an epistemology mindful of traditional stigma could help to develop new theorising, which would
construct new ways of practicing and researching issues that are relevant to disabled people.
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Voicing the identities of disabled people

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Abstract

This research explored how 12 people, with a range of physical impairments spoke about themselves considering how, if at all, disability features in their identities. This included a consideration of whether they identified with a sense of group or cultural disabled identity. A version of the voice centred relational method was used in order to facilitate an exploration of the participants' subjective experiences, whilst being aware of how the researcher and the research process may affect the findings. This research concluded that the participants minimized their impairments, distancing themselves from the label of disability and that the participants' voices were often silenced, either by themselves or others. Further to this, it was found that none of the participants strongly identified with a disabled group or cultural identity. Some of the implications this may have for psychological practitioners were also considered.
Biographical details

I am a twenty-six year old disabled person. I have a degenerative eye condition which means I have been registered blind since the age of twenty-one. This research was undertaken as part of my doctorate in Psychotherapeutic and Counselling Psychology. I chose to train as a Counselling Psychologist as its epistemological stance encourages a critical exploration of traditional psychological practice, whilst also allowing me to practice as a therapist. My keen interest in the Disability Movement led me to undertake research using a social model of disability. The stance I took in the research aimed to facilitate a new way of exploring the experiences of disabled people.
Voicing the identities of disabled people

Introduction

In this research I was interested in listening to how people with a variety of physical impairments speak about themselves, considering how, if at all, disability features in their identities. This research emerged from some of the conclusions I drew from a literature review, undertaken during my doctorate, which looked at representations of disability in contemporary psychological literature (Supple, 2001). It soon became apparent to me that not only was the issue of disability under-represented in the literature, but that it was also perpetuating a certain perception of disabled people.

I reviewed psychological research published between 1999 and 2001 in order to explore what representations of 'disability' were embedded in the work, and what presumptions were inherent to such representations. This held interest for me not just as a disabled person registered blind, but also as a counselling psychologist in training. A social model of disability was adopted throughout the review. This differentiates physical impairment from disability (Shakespeare, 1993). This stance asserts that the former comprises the embodied restrictions of a certain physical state whilst the latter stems from social and physical barriers, which inhibit personal choice (Oliver, 1996).

The thematic organisation of the papers in the review led to some broad areas of research being identified. These were (1) personal and mental attributes (including affect and identity), (2) quality of life (including sexuality, reproduction and...
discrimination) and (3) therapy. The literature was discussed from a material discursive stance (see Yardley, 1997). This enabled a consideration of the language and representations embedded in the research. This explored the role psychology may play in the creation and perpetuation of certain negative representations pertaining to disabled people.

The majority of the literature included presumptions stemming from the traditional view of disability based on an individualised medical model, which sees disability as a personal tragedy caused by a physical state (Burman, 1994; Oliver, 1989). Also, it was found that throughout the literature 'disabled people' were treated as a group, distinct from the 'non-disabled', although the criteria for inclusion or exclusion were rarely attended to and never clearly defined.

Further to this, following the review, I reflected on how certain representations, combined with a specific epistemological stance, may have affected the collection and production of new knowledge. That is, a positivist empirical approach to such research may have led to de-contextualised findings, lacking in any accounts of the subjective experience of disabled people, which may have upheld traditional expectations and representations (Abberley, 1987; Luborsky, 1995; Oliver, 1992). Therefore, in this research, the meaning constructed between researcher and participant was held as central. It was hoped that this, combined with an awareness of the socio-cultural context, facilitated a phenomenological understanding of issues related to disability, whilst recognising the diversity both within and between physical states.
The literature review found that research based on the social model of disability focused on forming a positive self-concept in order to facilitate positive personal or socio-political change (Stewart & Bhagwanjee, 1999). It is suggested that this is achieved by conceptualising a disabled cultural identity as salient (Chambers, 1999; French, Gilson and Depoy, 2000) and overwhelmingly positive (Supple, 2001). However, this seems to make presumptions about the experiences and identities of disabled people. This research used a social model of disability. Therefore, the term 'disabled people' was used to refer to the socially constructed nature of disability rather than the term 'people with disabilities', which implies an individualised perspective by placing the disability with the individual rather than society. The research explored personal accounts by listening to the voices of people with physical impairments regarding their sense of identity. This aimed to investigate the ways in which disability features, if at all, within conceptualisations of the self, and the factors and processes by which such an identity is constructed. This may contribute to psychological work undertaken pertaining to disabled people and inform the theory and practice of psychological practitioners, including counselling psychologists. Furthermore, it may contribute to the debate on whether disabled people need counselling, as raised by Joy Lenny (1993). This research may enable psychological practitioners to consider a client's own perspective on their physical impairment and disability, rather than adopting traditional representations or an 'academic' version regarding this. Thus, how a client's disability may impact upon their lives could be considered without making presumptions about its salience. Furthermore, it may help give practitioners a way of formulating about clients who may not have integrated their physical impairment or experiences of disability into their identity.
Hearing the voices - theory and stance

This research facilitated an exploration of disabled identity, by listening to how disabled people talk about themselves and considering what may be salient to their sense of self. Identity will be considered as a dynamic process, rather than a static phenomenon. Also, it was considered how social representations and expectations of impairment and disability occur in the participants' accounts and the research relationships.

This was done by listening to the 'voices' of the participants. Brown and Gilligan (1993) conceptualised 'voice' as "our channel of connection, a pathway that brings the inner psychic world of feelings and thoughts out into the open air of relationships where it can be heard by oneself and others" (p. 15). They acknowledge the physical aspect of speaking and feel that voice connects psyche and body. They also assert that, as voice is in language, it connects psyche and culture. The definition of voice adopted in this research incorporates the latter point, defining voice in terms of the ways we are able to speak about ourselves. It also acknowledges that the embodied nature of experience may be significant, especially for disabled people. However, rather than seeing voice as a way of accessing the psyche of a bounded individual, it sees that our sense of self is constructed through our interactions. That is, we are shaped by the resources we have available to communicate about ourselves. This includes communicating externally (with others) but also internally (with ourselves). Ribbens and Edwards (1998) suggest that our identities are formed through our voices and thus shaped by the process of performing to the 'other', aware of an audience, even if this is oneself. This is similar to the notion of 'discourse' used by some social
constructionists, perceived as a resource or framework used in the construction of particular phenomena associated with specific individuals, groups and institutions (McNamee & Gergen, 1992; Yardley, 1997). Therefore, voice is seen as reflecting the knowledge we have about our selves and our experiences, which in turn is regulated by the resources and representations dictated by our socio-cultural context. This will silence some voices whilst encouraging others because certain dominant discourses are privileged, such as the medicalised perspective of disability over the social one (Burman, 1994; Yardley, 1997). Thus, not only do we have to consider the external representations of disability and impairment, but also the participants' own internalised representations and beliefs which will regulate their views regarding themselves and what they do or do not say. The research took into account that within any one participant's account there are multiple voices, including the researcher's.

The emphasis of this research was on participants' accounts, i.e. their voice, rather than psychological theory and research, although this will be referred to where relevant. This is because, by undertaking formal research, I brought private accounts into a public domain (Ribbens & Edwards, 1998) and thus I needed to be mindful of what the presumptions of such a domain were. That is, the domain of psychology is dominated by a discourse that may oppress the voices of the participants through the traditional psychological perspective of disability and impairment (Burman, 1994). Therefore, the accounts were not forced into a theoretical framework, due to the concern raised by Smith (1987) and Devault (1994), that to do so would pull the research towards a conventional understanding and reshape voices in terms of a dominant discourse, so obscuring the participants' own meaning. Ribbens and Edwards (1998) suggest that one task in research is to find the different voices in the
research, including the researcher's, but especially "the muted voices of those we are aiming to give voice to whilst being aware of how an audience may effect what is spoken" (p.18). They feel that listening in this way opens up opportunities to consider some of the complexities of being, in this case being disabled. Thus, it was hoped that individual accounts could be listened to whilst also making space for diversity in experience. As a disabled person and a researcher, I hoped to be able to bridge the gap between private (daily experiences) and public (academic work) domains, whilst also realising that I would have heard the participants' voices according to my own perspective.

Method

Participants

Twelve participants were recruited for this research, with a range of physical impairments (see Table I below).

Before any potential participants were contacted ethical approval was obtained from the University of Surrey's Advisory Committee on Ethics (see appendix A). Participants were contacted through local disability groups and agencies, as well as through my family and friends. Potential participants were provided with written and verbal information about what the research involved (see appendix B). The participants either considered themselves disabled or had a physical impairment that they reported as having had an impact upon their life. This included people that do not automatically refer to themselves as disabled, in order to explore decisions about
inclusion into this category. A version of theoretical sampling was used in order to ensure diversity (Pidgeon, 1996). That is, voices that were found to be missing, for example older participants, were included in later interviews. This did not include people with mental health issues or learning disabilities as this may have made a small sample overly diverse. However, a range in age, gender, class and occupation was included. I am aware that there is little diversity in ethnicity or sexuality, which may be issues to be considered in future research.
<table>
<thead>
<tr>
<th>Name (pseudonym)</th>
<th>Gender</th>
<th>Age</th>
<th>Disability (In own words)</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owen M</td>
<td>M</td>
<td>20</td>
<td>Mild cerebral palsy</td>
<td>Student</td>
</tr>
<tr>
<td>Tina F</td>
<td>F</td>
<td>21</td>
<td>Two strokes, hydrocephalus</td>
<td>Student</td>
</tr>
<tr>
<td>Janet F</td>
<td>F</td>
<td>52</td>
<td>Severely deaf</td>
<td>Technician</td>
</tr>
<tr>
<td>Sarah F</td>
<td>F</td>
<td>53</td>
<td>Multiple sclerosis, epilepsy</td>
<td>Retired teacher</td>
</tr>
<tr>
<td>Frank M</td>
<td>M</td>
<td>62</td>
<td>Multiple sclerosis</td>
<td>None</td>
</tr>
<tr>
<td>Claire F</td>
<td>F</td>
<td>53</td>
<td>Polio</td>
<td>Retired</td>
</tr>
<tr>
<td>Lucy F</td>
<td>F</td>
<td>25</td>
<td>Undiagnosed endometriosis</td>
<td>Justice administrator</td>
</tr>
<tr>
<td>Bob M</td>
<td>M</td>
<td>38</td>
<td>Blind</td>
<td>IT Consultant</td>
</tr>
<tr>
<td>Tom M</td>
<td>M</td>
<td>60</td>
<td>Weak leg due to polio, heart disease</td>
<td>Retired</td>
</tr>
<tr>
<td>Betty F</td>
<td>F</td>
<td>75</td>
<td>Three strokes, heart problems</td>
<td>Retired nurse</td>
</tr>
<tr>
<td>Ann F</td>
<td>F</td>
<td>70</td>
<td>Arthritis in hands and spine, 3 discs removed from back</td>
<td>Retired</td>
</tr>
<tr>
<td>Angela F</td>
<td>F</td>
<td>15</td>
<td>Spina bifida occulta</td>
<td>Student</td>
</tr>
</tbody>
</table>
At the interview, the procedure and issues of confidentiality were explained and each participant's written consent to participate in a recorded interview was obtained before starting (see appendix C for a sample consent form). One participant was under the age of 18 years, so parental consent was obtained in addition. All participants were made aware before the interview that they may withdraw from the research at any time, and after the interview an opportunity was provided for participants to reflect on their experiences.

**Data collection**

The research used unstructured interviews of approximately one-hour duration. The interviews were used to consider, with the participant, what issues they perceived to be important concerning their sense of identity. This included what factors they considered salient in the content and value of their identity, with a view to finding out what, if any, connection this has to their physical impairment or disability. The 'who am I?' question was used to initiate the interview (see appendix D; Khun & McPartland, 1953). That is, the participant was asked to identify up to twenty words to describe themselves and was then asked to discuss their answers. This was used to facilitate a broader discussion of what the participant felt was relevant to the topic of identity.

A version of the voice centred relational method was used in the analysis (as defined by Taylor et al, 1996), which influenced how the interviews were conducted. The method aims to give 'voice' to the participants within their own framework of understanding, whilst acknowledging the effect that the researcher's own framework
may have. This aimed to avoid presuming there is a 'right' way of perceiving disability. The method considers who is listening as well as who is speaking; "through this relationship a narrative account is produced interactively, depending not only on the questions of the interviewer and the experiences of the narrator, but also on the 'social location' of both" (Taylor et al., 1996, p. 235). This aimed to consider the accounts of disabled people in a way that would acknowledge their individual experiences, rather than homogenising them as 'the disabled'.

No specific pre-set questions were asked after the 'who am I?' question as the voice centred relational method involves following the participant's line of thought. This aimed to facilitate the participant and researcher to work together in an interpretative relationship. Topics that arose in earlier interviews were brought into later ones in order to ascertain if these were shared experiences and views.

**Analytic procedure**

The interviews were transcribed verbatim which were used by the sighted members of the analytic team. However, as I am partially blind the taped version was kept and used in the analysis instead of working from the transcript. The transcripts were analysed using a version of the voice centred relational method that was adapted for specific use in this research (see Taylor et al., 1996).

The analysis was undertaken partly in a group comprising three psychologists who are experienced in qualitative research (two social psychologists and one developmental/counselling psychologist) and a colleague who used the same method
in her research. This method requires that each transcript is read four times, each time listening in a different way.

The first step of the analysis involved each member of the analytic group reading through a transcript attending to the overall narrative, the researcher/participant relationship, the questions asked, the stories being told and the researcher’s responses. The group reported their findings and these were discussed before going on to the second reading.

In the work undertaken by Taylor et al. (1996), the second reading involved listening for the first person voice, i.e. the ‘I’. This was adapted for this study to listen for how the person spoke about themselves more broadly, inclusive of how this was shown through relationship. Thus, how the participants speak about themselves and about how they think and feel were attended to. This includes considering any gaps or what might be termed 'notable absences' in their accounts. Similarly, the findings were summarised and discussed in the analytic group, paying particular attention to how the members of the group differed in what they focused on. The same process was repeated for the third and fourth readings.

The third reading was also adapted for use in this research. In Taylor et al.'s (1996) research, this reading listened for political resistance. However here, it was used to consider representations of disability. It was used to listen for such representations in how the participants relate to themselves and disability and physical impairment, as well as through their ways of relating to the 'other' inclusive of peers, family members, institutions, and societal representations.
The fourth reading used by Taylor et al. (1996) listened for evidence of psychological distress or loss. This reading was also adapted to listen for evidence of an awareness of a social model of disability (Oliver, 1989), specifically looking for a disabled cultural identity as outlined by Chambers (1999) and French, Gilson and Depoy (2000). This aimed to explore if there was a sense of 'cultural' or 'group identity' amongst the participants. This process was repeated with other transcripts; however time restrictions meant the group could not carry out all four readings with all the transcripts. Nevertheless, I read all the transcripts four times, listening as outlined above. The summaries of these readings were organised thematically and were discussed with the analytic group as well as with members of an internet disability research discussion group.

The voice centred relational method has, in the past, been used and adapted by different researchers according to their individual topics, samples, theoretical and academic environments, as well as their social and cultural contexts (Doucet & Mauthner, 2001). This research uses its own interpretation of the method, in order to facilitate an exploration of identity and disability which could not have been achieved using the original readings. This version also allows the position and context of the researcher to be incorporated.

As this type of analysis is subjective, the group nature of the analysis was used to curb any overly idiosyncratic interpretations, stopping them becoming incongruent with the participants' accounts. However, the differing subject positions of the members of the analytic group, including my own as a disabled person, were drawn upon, providing a
rich analysis. The nature of the analysis hoped to identify multi-layered voices and areas where there was conflict or contradiction both within the analytic group and the participants' accounts. This process provided resources which could be utilised in the analysis.

The underlying epistemology of this method means that traditional measures of reliability are not appropriate. This is because it does not adopt a positivist approach which views the researcher as an objective observer. Persuasiveness has been suggested as an alternative criterion for evaluating qualitative research (Elliott, Fischer & Rennie, 1999; Smith, 1996). Therefore, excerpts from the transcripts have been used in the analysis as it has been suggested that their inclusion enables readers to assess the persuasiveness of the analysis (Touroni & Coyle, 2002). In these excerpts ellipsis points (...) have been used to indicate where material has been omitted, and brackets have been used within a quotation to clarify contextual information.

Analysis

Denial?

The themes identified below seem to cluster around denial. That is, the participants reported minimising their physical impairment and any negative consequences of it. They also seemed unable to speak about their experiences of disability and rejected a disabled identity. As the method aims to include my presence as the researcher, I took
some time to reflect on why this theme of denial was focused upon (Doucet & Mauthner, 2001).

My own experience of having a degenerative condition affecting my sight led me to consider how disabled people have to deny something about themselves, their physical impairment or their experiences of disability. This was reinforced by Sally French's article 'Can you see the rainbow? The roots of denial' (1993). In this, French discusses how she learned at an early age that, in order to avoid pressure to 'perform' and to alleviate the anxieties of those around her, she had to deny her disability. Part of this was adults not believing her or encouraging her to minimise the appearance or experience of her sight loss. She saw that this, in part, reflected people's confusion about impairment but also their reluctance to take instruction on the matter from a disabled person. French concludes that the denial of one's disability is completely rational in order to avoid negative responses such as anxiety, disapproval, disbelief and disappointment from others in one's social environment. She sees that disabled people "deny our disabilities for social, economic and emotional survival and we do so at considerable cost to our sense of self and our identities, it is not something we do because of flaws in our individual psyches" (French, 1993, p. 77). Similarly, this research does not view the various forms of denial that I shall discuss in any negative sense but as something that society promotes regarding disability as well as a coping strategy. Thus, issues of denial were held in mind during the research. Although I may have brought my own expectations to the research, this subject was evident in the voices of the participants.
Hiding ones physical impairment or experience of disability

The first theme was concerned with how the participants hide their physical impairments, and what affects this. Tina spoke about her concern that people would judge her because of her hydrocephalus. She has only told a few close friends and is worried she may scare people by telling them. When I asked what the concern was about telling people, she replied "that they get scared, when I first told my boyfriend he was physically sick, so it was like ok, um, that didn't go down too well". Thus she has decided not to tell people - "I don't like to tell people about it 'cos then I think they put me in a box or judge me". The participants' past experiences affect whether they tell others about their impairment or not. Janet states that "I wouldn't tell someone before I met them unless I had to, I want to see how much I can get away with". She finds that people treat her differently once they know she is deaf - "they treat me better in a way if I don't tell them, if they know they give me less responsibility." The participants felt more obliged to hide any physical 'difference' when they were young. For example, Tom recalled how when he was at school, although short trousers were part of the uniform, he would wear long trousers to hide the callipers he wore due to his polio. The youngest participant (Angela) seemed to put most energy into hiding her physical impairment. This is perhaps understandable, as she had to move school twice because of the bullying she experienced due to her spina bifida. She often hides the cause of her impairment, instead attributing it to an accident, "maybe because if I'd had an accident it means I wasn't born weird or anything like that, people are ok about it, and accept it". She sees that to be open about her physical impairment means threatening the way she views herself - "I do try
and be open but I don't want to attention seek, I don't want to make a fuss, or be special or different, 'cos I want to be like everyone else, that's all I've ever wanted".

Traditionally, the minimising or hiding of one's physical impairment or experience of disability has been understood within psychology as a problem lying within the individual, a maladaptive reaction to a loss (Lenny, 1993). Such responses have been pathologised and likened to bereavement reactions (Wright, 1960), rather than seen as a reasonable reaction to a dis-empowered societal position (Swaine & French, 2000). Alternatively, as French (1993) suggests, the way these participants minimise or hide their impairment could be understood as a way of avoiding potential negative reactions. This would be supported by Weiserb and Gottlieb's (2001) research, which suggested that minimising the pervasive impact of a physical impairment may serve to improve social relationships. Similarly, Harper (1999) found that the more obvious a person's physical impairment, the more they were avoided, and the less desirable they were perceived to be as friends. Both of these studies were carried out with children, which could relate to the fact that most participants spoke about how they felt more obliged to hide their impairment when young. This may imply that there is more pressure to appear 'normal' whilst developing one's sense of identity during childhood.

Hiding one's physical impairment was affected by context and the nature of the impairment. Sarah seems to feel that she is unable to hide her multiple sclerosis (MS) - "I actually forget it most of the time, some people remind you of it, but you've got to take into consideration I use an electric wheelchair". It seems that others treat Sarah's MS as a salient feature of her identity. She feels that others are acutely aware of her physical impairment, constantly reminding her of it, - "so, that to me is a reminder the
whole time, I just feel like saying just treat me as a person". She chooses not to tell people about the other, non-visible impairments she has, such as epilepsy and visual impairment, because she feels this would overwhelm others - "they wouldn't cope, they'd think, oh, something else."

The hiding of one's impairment may serve to make social interactions easier and may also play a role in resisting the label of disability, which seems to be perceived as negative. Stone (1995) suggests that our society promotes the attainment of bodily perfection, which she asserts is unobtainable. She feels that those with a clearly visible impairment are more likely to be labelled as disabled and thus be subject to the ensuing oppression. Thus, hiding one's impairment may be an attempt to avoid being seen as imperfect and, thus, marginalized. Guthrie and Castelnuovo (2001) see that a positive body image, for disabled women, is central to the development of a positive self-image. In their research they assert that a positive identity is achieved by either changing the body through exercise or by minimising the body's importance. It may be that the participants achieve a positive self-image by minimising or denying the aspects of their bodies which may not fit into a positive definition of self.

As a child, it seems that Owen put a lot of effort into minimising his physical impairment by reducing the visible effects of his cerebral palsy - "I've worked like hell to make sure my arm, when you do get a tendency it rises, and I've really worked on this because that has to be the thing that makes it most obvious, it's the combination of having it turned in but also rising up the side." However now, as an adult, he seems to want to be open about his cerebral palsy, at least partially: "it does help when people don't notice but I don't mind when they do". Thus his personal voice, which
has worked towards hiding his impairment seems to conflict with his political voice, which is heard through his work as a disability representative and calls for the recognition of disability related issues and needs. He stressed how important he felt it was to avoid being negative about his impairment, often highlighting the positive benefits it has. This could reflect the presence of a positive disabled identity (Swaine & French, 2000) or it may be a way of dealing with his day-to-day interactions. However, I wondered why Owen continued to minimise his impairment during the interview. The analytic group highlighted our conflicting voices concerning this, whereby I challenged how Owen minimised any negative consequences. This may imply that the participant felt he had to either adopt a traditional perspective of disability or deny the impact of his impairment. That is, he may not have been given the opportunity to re-define disability according to the social model perspective.

Hiding one's impairment or disability may be a strategy to avoid the hostility towards disabled people, that Barker, Wright, Meyerson and Gonick (1953) suggest is shown towards disabled people, as well as the nervous and awkward reactions that Young (1990) suggest disabled people can provoke in non-disabled people, which he suggests can lead to avoidance. This may be what Owen is trying to evade when he talks about avoiding the awkwardness people can feel about his disability - "I don’t do awkward situations .... if you're going to spend time with me, part of that is ... although I understand why people do it, people apologise when they find out and the awkwardness that comes from it, um, I think it's not necessary and therefore has made me into a person that will not um, enter an awkward or be in an awkward situation". The participants speak about having to hide their impairments, either physically or by
not speaking about their experiences of disability. This sense of being silenced or self-silencing is expanded on in the next theme.

Silence and speaking

The second theme looks at how the participants could speak about themselves, including what went unsaid in their lives. Tina seems to feel she cannot be open about her hydrocephalus - "I've got another friend who's, um, got a disability and she's quite open about it, um, but I don't feel I can be". She feels this is partly because her mum used to speak for her as a child regarding her disability and now she is scared of what people's reactions will be if she tells them. Janet felt at school no-one ever asked her what it was like for her and she felt unable to tell them -"I suppose I didn't want to show myself up, I wasn't really that sort of person". Her school told her she was 'no different' which seemed to close off any opportunities for her to express her needs. She said "you just have to go along with it, I mean you didn't get treated any differently so you just had to get on really". It seems that this has carried on today and that she feels unable to talk to people about her experiences of deafness.

Sarah finds that strangers do not ask her about her physical impairment and those who know her stop asking her eventually. She seems to feel that people are very conscious of her physical impairment, but at the same time find it hard to speak about it. Sarah said "One of the mums actually came up to me and said 'do you mind me asking what is wrong with you?' and I said 'no I don't mind if you ask at all', 'how much can you do?' ... later on she came over and said 'I haven't offended you have I'? I said 'no, not at all, I'd rather you asked.'" This seems to imply that there is some caution regarding
discussing Sarah's impairment. This may reflect a wider societal taboo regarding speaking about physical impairment which may, in turn, perpetuate disability by keeping disabled people as unknown and 'other'. That is, it reinforces the idea that it is offensive to speak about physical impairment. This may stem from the historical belief that impairment results in feelings of guilt and shame (Chaudhuri, 1999; Lindemann, 1981). Further, it seems that some ways of speaking about impairment are more acceptable than others. An example of this may be how people speak to Sarah's companion (Jane) rather than her - "Just occasionally you think, oh somebody take some notice of me .... a lot of people talk to Jane not me". This may be a way of avoiding awkward conversations with disabled people, but may also reflect the 'does she take sugar?' attitude, which so often restricts the autonomy and voice of disabled people. However, Sarah sometimes seems to choose her silence - "No you don't tell them, one or two people have questioned this and when I tell them they start to panic they can't cope, you see them turning greener and greener but you shouldn't have asked, don't ask if you don't want to know". There seems to be some frustration here that people don't really want to know how things are for her. Although the participants often spoke about how non-disabled people do 'not know' about their experiences of disability a lack of space means this can not be expanded upon here.

Humour was often seen as a way of speaking about one's disability. Owen finds that humour is a way of talking about his cerebral palsy - "I like people that make fun of it, in a funny way, I like that way of appreciating it better, than someone who's a bit 'oh I'm sorry'". Humour may be a strategy to make disability 'speakable', and is seen within psychoanalytic work as a mature and useful defence (Woolfe & Dryden, 1998).
However, it could also serve to stop serious conversation being held about the experience of impairment and disability.

Owen appreciates being able to speak about his impairment freely - "it's changed into healthy curiosity which I quite like, healthy curiosity and people are like, 'you know, what happened to you? Can I have a look at it', and I don't feel like a freak, if someone wants to look at it, because I think well yea, fine". The combination of humour, openness and the avoidance of awkwardness seemed to mean that Owen has developed a way that he can talk about his impairment. However, some ways of talking about his cerebral palsy seemed more acceptable than others. He speaks about 'having something wrong with his hand', and does this by taking a person aside in order to protect them from feeling embarrassed or guilty. Owen's way of explaining his cerebral palsy in laymen's terms, rather than using medical terminology, may show that there is uncertainty and a lack of knowledge about impairment. This would be further implied by Sheppard, Krampe, Danner and Berdine's (2002) findings that academic staff only had basic knowledge about a range of impairments. However, it may also reflect that Owen is trying to distance himself from a medical model of impairment. It may also be that Owen feels able to talk about his physical impairment but not his experiences of disability.

Frank finds that, although he is able to be open when people come up to him in the street and offer help, he does not feel comfortable talking to his friends about his MS - "no I wouldn't tell others, you become a moaner, a moaning Minnie or something like that, and I don't like that". Thus Frank seems to perceive that if he speaks about any negative aspects of his impairment that he is moaning. The stereotype that 'to speak is
to moan' (Finkelstein, 1980) may be a factor in self-silencing. However, as well as the participants self-silencing, pressure not to talk about impairment or disability seems to also come from others. Frank reflected that he is silenced, even by those who share some of his experiences, i.e. those at the disabled club - "we don't talk about it, I've even had one saying to me 'don't keep talking about disabled issues', they don't like it". Similarly, Bob spoke about how his family never discussed his sight loss - "She (his mother) would never talk about it, no not outwardly, no it's difficult because my father paid no attention...my father didn't really want to have any interest in it". It also seems that the participants' silence can be a reaction to how others respond to them. Anne feels she could not speak about her chronic back pain in the office because of how her colleagues perceived her - "I was the misery guts in the office because I was in constant pain, but no-one asked why". Angela reported feeling unable to speak about her spina bifida due to the negative reactions she has experienced from her peers. She explained that when she speaks about her physical impairment that people feel she is attention seeking. Also, she feels that she cannot speak to medical professionals about her impairment - "I used to feel like a rag doll, like an experiment, scared to talk back to them in case they did more tests, no-one listened to me". She had not had a chance to talk about her experiences prior to the interview. She cannot talk to her friends as she feels they cannot be trusted, she cannot tell medical professionals as they would not understand and she cannot tell her family because it may upset them. Thus she perceived her only option was to silence her voice by trying to hide her impairment and deny her experiences of disability. This would seem to agree with French's (1993) assertion that she had to remain silent about her difficult experiences, rather than risking upsetting those around her.
Lucy introduced the idea that some types of physical impairment may be more unspeakable than others. She wondered if her disability was more taboo because it involved her reproductive system - "there might even be a sense of reproduction being under threat so it might be something that doesn't want to be confronted...and because it's women's things, people don't like dabbling in women's things". She feels that not speaking about it is a way of coping and that it is a personal subject. This may highlight the taboo surrounding sexuality, especially in relation to disability (Hallum, 1995), and that certain impairments may have a strong gendered aspect to them. However, when I asked if this, non-speaking, was about people not wanting to know she disagreed and said - "I wouldn't presume that people don't want to know, but I probably wouldn't want to take them there". Thus the participants' silence seems to be affected by their interactions with others. This could be related to knowing when it is safe to speak, as examined at by Tasker and Golombok (1997), in their work on children of lesbian parents.

The participants' silence may also play a role in protecting both themselves and others. This could stem from a traditional representation of disability as upsetting, destructive or damaging in some way. Claire reported that she did not speak to her family when she saw her body becoming less mobile, in order to protect them - "I was so frightened, I couldn't discuss even that with my husband until I'd sorted out in my mind how I was going to cope .... I think when you're in my position you don't worry about yourself so much, it's how the family's going to cope, you fear for the family". Similarly, Betty, who remembered back to when she had her first stroke, said "I didn't really think of myself at all, I kept on worrying about my husband, I just kept on thinking he's got all this work to do". This may imply that Betty felt her husband had
to be protected from the burden of having a disabled wife. Therefore, it seems as though the participants feel responsible, at least in part, for how people react to their disabilities, protecting others from any discomfort. This may reflect Chaudhuri's (1999) assertion that disability threatens the non-disabled, provoking feelings of anxiety concerning one's own mortality, wholeness and ability.

It seems that there is a diversity of reasons why participants silence themselves, deriving from a complex interaction of individuals' beliefs and context which make it more or less acceptable to speak about one's disability in certain ways. Furthermore, it also seems to be a feature of participants' interactions with others, that is, the 'other' may also act to perpetuate the silencing. This could be considered in terms of Billig's (1997) assertion that repression occurs in conversation. He feels repression that occurs routinely in interaction is the result of social convention, steering us away from taboo topics. He suggests that the repression experienced in our interactions may lead us to repress ourselves internally. Similarly, Jack (1991) suggests that women are self-silenced by an internalised inner voice, which restricts or allows certain behaviours. Mead (1956) suggests such internalised norms are the form by which a community exercises control over the conduct of its individual members. Furthermore, if the participants' voices are being silenced regarding their experiences of disability this may impact on how they think about themselves and, therefore, affect their sense of identity.
Denying the negative

There was also some discussion from the participants about how they downplayed or denied some of the negative consequences of their physical impairment. This may imply that the disabling effects of one's impairment, constructed and perpetuated by societal exclusion, are strongly silenced. This form of silencing seems to relate to how the participants chose to silence their own voices or felt that they were being silenced. Bob felt that he was denied the opportunity to express his negative emotions. "The old adage with the guide dogs was that you always accepted help and were always gracious about it because you were an ambassador for the guide dogs...but my attitude is well, what they need to understand is that I'm having an off day and I got out the wrong side of the bed just like everyone else does, it should be no different but people don't do that". Sarah also felt that she wasn't allowed to talk about her negative feelings - "I mean, I have off days just like anyone else and they're allowed their off days". However, she also sees this as playing a certain function, - "If they knew me well enough, I'm a good actress, and most of the time you act and everything is just hunky dory because you do protect yourself in a way. I want them to see disability as just part of life and I'd love it to be that you could be down as well as up".

At first I perceived the rejection of negative experiences as positive, as a strategy to resist the traditional stereotype of disability as destructive and tragic (Meyers, 2000). This could have reflected the participants' desire to define themselves and their identity in positive ways, as suggested in Swain and French's (2000) affirmation model of disability.
However, this also involves denying some of the experiences of being disabled. The positive aspects of a disabled person's life should not be ignored, but to deny negative experiences is to deny ones embodied experiences and possibly a part of day-to-day life. Taylor et al. (1996) see that resisting negativity can play an important part in resisting societal expectations. Nevertheless, refusing to acknowledge the negative aspects of disability may allow the rejection of a negative stereotype for oneself, whilst still associating it with other disabled people. Also, to be silent about the negative aspects of one's disability may further contribute to non-disabled people 'not knowing' what it is like to be disabled.

**Identifying with a disabled group membership.**

This research used a social model when conceptualising disability (Oliver, 1989; Shakespeare, 1993). This differentiates physical impairment from disability, asserting that the former is a physical state whilst the latter is a consequence of a disabling physical and social environment. Gilson, Tusler and Gill (1997) suggest that social explanations of disability should include a positive disabled identity and thus disabled community. However, the participants did not seem to conceptualise disability according to the social model. This surprised me as the Disability Movement bases its political aspirations on such a definition of disability, campaigning to have the government replace the traditional medical definition. Further to this, the participants did not seem to have any sense of a group or cultural identity, as outlined by Chambers (1999) and French, Gilson and Depoy (2000). This raises questions about how the disability movement can be representative of disabled people if the concept of disability and identity that it uses are not widely held. However, the fact that the
participants felt silenced might mean that they had not had the opportunity to participate in a discussion forum that facilitates an exploration of alternative positive ways of talking about their disability. Furthermore, the fact that I have adopted such a disabled identity does not mean that I should overlook the participants' differing subjective experiences and the fact that some disabled people may choose not to adopt the social model.

Claire campaigns for access to the countryside for disabled people. Although she supports a social explanation of disability, she does not embrace disability as a positive identity - "I've always had this feeling that everybody's disabled in some way or another, um, but until now it's really hit home because now I'm actually, it's society, it's society that I find is restricting me, I think that's what it is ... so it's only now that I can't do as many things as I used to that I feel I'm in that disabled slot, which I don't really like.... I don't want to be disabled". She chooses not to attend polio club - "I don't know about just sticking with disabled, I find the polio club very hard to go to". This would seem to contradict findings by Hahn and Beaulaurier (2001) that disabled campaigners identify closely with a disabled identity.

It seems that the participants did not take on disability as an identity for themselves. Janet, who has been deaf from birth, never considered herself as disabled, until someone else ascribed the label to her - "I remember when I was at work and somebody they urm, said disabled person or something and I think I was quite shocked because I don't think of myself like that". Deafness has historically been conceptualised as a strong cultural identity (Chambers, 1999) but Janet, although having deaf friends and family, does not feel she has a deaf or disabled identity or
community. It seems that the participants, more than not identifying themselves as disabled, actively shun being associated with other disabled people. When Tina was a child she was encouraged to join a group for those with hydrocephalus, but she found this hard - "and there were people with disabilities there and obviously they were more severe than what I was and I couldn’t identify and I was like I can't identify with this group of people...I couldn’t stand it to tell you the truth". Similarly, Angela did not want to attend a group for people with spina bifida. The hospital told her there was a group she could attend but "I was so sort of ashamed, I didn't want anyone to know and just didn't want anything to do with it". It seemed that the participants did not want to be categorized as part of a disabled group. Sarah does not like the way our society categorizes people as either disabled or non-disabled - "they wear glasses, he's bald, his hearing is affected but you don’t see them as disabled and I am'. She does not wish to be put into a group according to her impairment or experiences of disability - "I don’t want to belong to a group I just want to belong to this world, I don’t want to be put into a group, and there is the MS society and I don’t go to that because I don’t feel just because we're all in wheelchairs that we've necessarily got anything in common". Bob identifies with blind people but does not identify with disabled people more generally, as he feels this is negative - "No, when people mention disabled people I don't suddenly think that's me but I don't think that's conscious, well mostly it's not a conscious effort to devolve myself from any sense of community, but I suppose it is a bit in the fact that sometimes I find the word disabled is a bit too disempowering for my liking, it's a bit too horrible".

However, there was a feeling that other disabled people could understand common experiences. Bob said "but if I talk to other blind and partially sighted people,
especially blind people, there is a common understanding of those experiences". Also Tina identifies herself as disabled in order to gain legal benefits - "I would purely for the fact that err it makes life easier... as in I get a disabled badge so it makes it easier parking and things like that, so and also err like with extra time, I get extra time in exams because of my stroke". Adopting a legal label may be the only way that the participants can get the support they need. That is, in order to have their voices heard they may need to use traditionally proscribed medical or tragic language.

Those participants who are wheelchair users seemed to be more inclined to use the term disability. Frank, Sarah and Claire, all of whom are wheelchair users, referred to themselves as disabled in reply to the 'who am I?' question, used at the beginning of the interview. This may imply that the stereotype, common sense view of a disabled person being a wheelchair user is evident in the voices of the participants. It may be difficult to find a way of speaking about one's disability without succumbing to stereotypical language and definitions of impairment. This stereotyped representation of disabled people contributes to the treatment of disabled people as a homogenous group, overlooking the diversity in experience and needs. This may make it difficult to have disability as part of, rather than salient to, one's identity. That is, a disabled identity may overshadow the other facets of identity seen as important. For example, answers to the 'who am I?' question included areas relating to the participants' occupations (e.g. student), their relationships (e.g. mother) or their beliefs (e.g. child of Christ). Therefore, the participants may feel their choice may be to be defined by one's disability or to resist such an identity altogether.
None of the participants seemed to have a sense of a positive disabled group identity, as defined by Gill (1997). He asserts that there are four stages involved in positive disability identity development. These are integrating into society, integrating with the disability community, internally integrating our sameness and difference, and integrating how we feel and how we present ourselves. None of the participants were familiar with the idea of a disabled cultural identity or community, and therefore did not identify with it.

Despite this, the analytic group felt that during the interviews the participants and myself were forming a kind of shared disabled identity. That is, they noticed that in our conversations the sharing of stories and experiences led to an identification of 'us' as disabled people, as opposed to 'them' as non-disabled people. This may imply that although the participants did not formally acknowledge a disabled identity something might happen in the interaction between disabled people that reinforces one's disabled-ness. In addition, it may have indicated that the participants hadn't been given an opportunity to choose a social explanation of disability. However, it could also have been because the conversation was biased by my own views on disability.

**Summary**

This research aimed to listen to the voices of twelve disabled people regarding how they spoke about their identities, specifically looking at how issues of disability interacted with this. It also aimed to consider whether a positive group disabled identity, as promoted by the Disability Movement, was present amongst the
participants. It seemed that the participants' voices served to silence their experiences of disability, instead speaking about how they hide or minimise their physical impairments. This, combined with how the participants distanced themselves from identifying as disabled, seems to imply that disability as an identity is not integrated into their self concepts. Furthermore, few of the participants had adopted social explanations of disability and did not identify with a disabled group or culture. This may be due to the fact the participants have not been exposed to such perspectives. Therefore, their voices may reflect the way they have found to cope with the negative stereotype of disability still prevalent in our society. This may imply that such a cultural disabled identity is politically rather than individually constructed. Thus, it may be that 'difference' can only be defined positively if gaining support from peers. That is, if the participants had no sense of belonging to a disabled group they may not have had support in finding a positive definition of disability, choosing to downplay their physical impairment, rather than reflecting on their experiences of being disabled. If this is the case, this way of coping means denying parts of ones-self, being unable to incorporate one's experiences of disability into one's identity or construct new perspectives or meanings regarding it. However the participants rejection of an ascribed disabled identity whether that be traditional or social could also be perceived not as a form of denial but rather as a way of constructing ones own identity. That is, the rejection of a social or medical model of disability may imply that the participants found that neither model provided a genuine way of reflecting on ones experiences of self. This could relate to the assertion made by Shakespeare and Watson (2001) that the social model, set in opposition to the medical model does not make space for an inclusion of multiple identities, including ones physical experiences of impairment, as well as other aspects of ones identity.
I acknowledge that, because I started the research mindful of French's (1993) work on denial, and of the Disability Movement's assertions concerning identity, that the work will have been biased towards these areas. The interactions within the interviews are likely to have foregrounded these topics as I conceptualise my own identity in terms of being a disabled person. However, such findings seemed to be strongly based in the accounts of the participants. I do not presume that these areas are the only topics discussed by the participants. There were countless other lines of enquiry that I could have pursued. For example there was not room to consider the gendered aspect of voice or to consider, in any depth, how age may effect what the participants felt able to say. However, I feel that the phenomenon of disabled people having to hide their impairments, or silence themselves, is important and in need of further research.

It is hoped that the method chosen enabled a more subjective way of listening to the voices of the participants. As the interviewer, I was not just a psychological researcher but also another disabled person, relishing the sharing of experiences. Therefore, my own choice of defining myself in terms of a disabled identity had to be balanced with the participants' right to choose how they define their own identity. Thus, I strove to find a balance between two disabled people talking and the public domain of academic writing (Ribbens & Edwards, 1998). Also, I had to find a way of balancing being 'a disabled person' with being a trainee counselling psychologist.

The findings of this research were of particular concern to me as a counselling psychologist in training, as previous research undertaken with disabled people may lead professionals in the field of psychology to conclude that disabled people have
either not psychologically adjusted to their disability or, in the newer research, given it saliency as part of a positive identity. Both of these may be overly simplistic and fail to describe how disabled people interact with their physical impairment and experiences of disability. The participants seemed to minimise their physical impairments whilst distancing themselves from disability as an identity. However, this may have been because the representation of disability they were familiar with was a traditional, tragic one. This may suggest that silencing or denial, rather than implying psychological maladjustment (Lenny, 1993), may be a coping mechanism used to survive in an ableist society. One of the tasks of any therapeutic intervention with disabled people may be to consider why people feel the need to distance themselves from their disability and to consider the experience of having to deny part of one's self. Thus, as Lenny (1993) suggests, one of the tasks of therapy may be to reflect on the relationship between individually experienced impairment and socially imposed disability. Future therapeutic work undertaken with disabled clients may need to consider their phenomenological experiences, as well as alternative meanings and perspectives relating to disability which may facilitate the development of a positive sense of self. Also, psychological practitioners need to reflect on the meaning they assign to disability, as this may affect transferential issues within therapeutic work, as well as therapeutic progress (Segal, 1996). There are several approaches that could be used to facilitate such work. Firstly, the client-centred approach may enable an exploration of disabled peoples' contexts and the meanings these have for them, as suggested by Lenny (1993). Secondly, affirmative psychotherapy (adapted from approaches developed in therapy undertaken with gay men and lesbians; Milton, Coyle and Legg, 2002) may enable an exploration of issues of oppression and negative representations regarding disability. Finally, the multicultural approach
suggested by Stebnicki, Rubin, Rollins and Turner (1999), could enable issues of
diversity within the individual to be considered.
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04 February 2002

Mrs Sarah Supple  
PsychD Student  
Department of Psychology  
University of Surrey

Dear Mrs Supple

**Voicing the identities of people with physical disabilities**  
(ACE/2001/97/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol (and the subsequent information supplied) and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee’s website at [http://www.surrey.ac.uk/Surrey/ACE/](http://www.surrey.ac.uk/Surrey/ACE/).

This letter of approval relates only to the study specified in your research protocol (ACE/2001/97/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 04 February 2002  
Date of expiry of approval by the Advisory Committee on Ethics: 03 February 2007

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)  
Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE  
Dr A Coyle, Supervisor, Dept of Psychology  
Dr M Finlay, Principle Investigator, Dept of Psychology
To whom it may concern,

I am contacting you to ask if you would consider participating in some research I am doing. I am interested in finding out how people with a range of physical disabilities think about their identity. This would involve talking to me for up to an hour about aspects of your life you feel are important to your identity. If you think this is something you might want to participate in there is an attached information sheet which will give you more details. If you are willing to participate please contact me and I will arrange to come and meet you. My contact details are on the attached information sheets. Thanks for your time,

Yours Faithfully,

Sarah Supple.
**Information sheet**

I am currently studying for a doctorate in Counselling Psychology at the University of Surrey. I am partially blind and am particularly interested in issues related to the perceptions of people with disabilities. I am currently conducting research in this area.

This study is interested in looking at how people with a range of disabilities think about their identities. I am interested in whether you feel your physical impairment is linked to your identity and how you think about yourself. This would involve us talking for about an hour in an open and honest way about the issues you feel are important to your sense of identity. This discussion will stem from the answers you give to the question 'who am I?'. With your permission this interview will be taped and some of the information on it will be used in my study. The tape and the information on it will only be used in this study and all details will remain confidential. That is your name and any identifying features, such as where you live will not be included in the write up and all tapes will be wiped blank after they have been used.

All of the information gathered will be discussed in a research group and I would like your opinion on our conclusions before the final write up. This research hopes to gain insight into how some people with disabilities think about their identities. This seems to me to be a misunderstood area and I hope that this work will open up a debate about disabled peoples views of themselves, stemming from the opinions and experiences of people with disabilities.

I agree to participate in the interview in a way that supports and facilitates you in exploring your sense of identity. I will endeavour to stay true to your thoughts and feelings in the interview and the write up of the study. You may cease the interview at any time should you choose to do so. There is no obligation to justify such a decision and no judgement or repercussions will occur from this. If at any time you wish to withdraw your taped interview from the study you may do so. Also if my conclusions do not agree with your opinions this will be included in the final write up.
My contact details and that of my supervisor, Dr. Adrian Coyle are:

Psychotherapeutic and Counselling PsychD Office  
Department of Psychology  
University of Surrey  
Guildford  
Surrey  
GU2 7XH

Telephone : 01483 879176  
E-mail: psm6sg@surrey.ac.uk

Many thanks,

Sarah Supple.
Consent Form.

I, the undersigned, voluntarily agree to take part in the study on aspects of identity. I have read and understood the information sheet provided. I have been given a full explanation by the investigator of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

I agree to participate in an interview with the investigator. I shall inform them immediately if I feel uncomfortable or wish to stop the interview. I understand that all documentation concerning me is in the strictest confidence and complies with the Data Protection Act 1998.

I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

I confirm that I have read and understood the above and freely consent to participate in this study. I have been given adequate time to consider my participation and agree to participate.

Name of volunteer: ___________________________ Date: __________
Signature: ___________________________

Name of witness: ___________________________ Date: __________
Signature: ___________________________

Name of researcher: Mrs. Sarah Supple Date: __________
Signature: ___________________________
Questionnaire

There are twenty numbered blanks on the page below. Please write up to twenty answers to the simple question 'Who am I?' in the blanks. Just give up to twenty answers to this question. Answer as if you were giving the answers to yourself, not to somebody else. Write the answers in the order that they occur to you. Don't worry about logic or 'importance'. Go along fairly fast for time is limited.

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Notes for Contributors

Contributors should bear in mind that they are addressing an international audience.
Manuscripts that do not conform to the requirements listed below will not be considered for
publication or returned to their authors. Submissions will be seen anonymously by two
referees.

Manuscripts, ideally between 3000 and 7000 words, should be sent to Professor Len Barton,
Disability & Society, Department of Educational Studies, University of Sheffield, 388 Glossop
Road, Sheffield S10 2JA, UK. Articles can be considered only if three complete copies of
each manuscript are submitted. They should be typed on one side of the paper, double
spaced, with ample margins, and bear the title of the contribution. The name(s) of the
author(s), the address where the work was carried out and full postal address of the author
who will check proofs and receive correspondence and offprints should also be included on a
separate sheet. Each article should be accompanied by an abstract of 100–150 words also on a
separate sheet, and a short note of biographical details. All pages should be numbered.

Footnotes to the text should be avoided wherever this is reasonably possible.

Tables and captions to illustrations. Tables must be typed out on separate sheets and not
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Transcript

I: So basically if we start by going through what you wrote down

P: Ok, erm I wrote down I'm a student, I'm a daughter, a friend, a girlfriend, a sister, erm a friendly person, erm a dedicated person, an artist, a ******** stroke ******** student and a swimmer (laugh)

I: So those are quite relational

P: Yeah

I: I suppose as the focus of what I am doing is about disability I'm really interested why you choose not to write down disability as part of your who am I, as part of your self concept and to me that's just as important as those people who do write it down...

P: yeah

I: so I suppose what I'd like to think about with you is if you see it fits into your sense of identity or if it doesn't how come? Kind of thing

P: errm I don't know I'm kind of, I don't like to tell people about it erm cos then I think they put me in a box or judge me or whatever so I like them to get to know me first and so that's why I don't usually put it down errm like I've got another friend who's errm got a disability and she's quite open about it errrm but I don't feel I can be, I don't know why. Its always been, since, because errm my mum found it out when I was little errm she's always dealt with it and so she's just carried on because obviously she had to force her way through to get people to listen to her that something was wrong with me..

I: Sure
P: so err soon, she's taken on that role, I've sort of taken a back step and sort of just er I don't know, just let her get on with it really like with organising my university stuff and all that stuff she always fills in the forms or anything like that so...

I: now you said like getting people to listen to your mum, is that something to do with the fact that its not a visible do you think?

P: errm yeah I think so errrm as it errrm I had it, my mum thinks I had it when I was born errrm as she had a difficult birth and everything and they said when I was born they raised a joke that I had a large head or whatever (laughs) so errm but she always thought there was something wrong with me because I couldn't walk, I couldn't talk, I couldn't do the normal things

I: Right

P: (laughs) errm what was the question again

I: whether it was difficult to get listened to..

P: yeah

I: because it's not visible

P: yeah, yeah definitely so yes so she went to our local errrm clinic or whatever errrm doctors and they kept saying o she's just a lazy person...

I: right

P: she's just you know, there's nothing wrong with her you're an overprotective mother so errrm when she finally did get this other doctor to see me who was part of it he said you know bring her to my home I think she should be assessed..

I: right
P: errm who basically watched me for an hour apparently, and errm he said at the end of it you know I think she’s got hydrocephalus so that’s when they, he diagnosed me and sent me up to great ormond street so errr so that’s when they found out really...

I: and do you think the fact that its not visible make a difference to whether you see it as part of yourself or not?

P: errrm....yeah I think it does actually I think if it was more visible I’d have to deal with it more but because it’s not I don’t have to deal with it

I: so it’s something like having a choice whether to inform people

P: yeah

I: and let people know.

P: definitely, sorry. Only if I really like get to know them and get to know their opinion of things and I trust them will I tell them.

I: So what’s the, whets the concern if you did tell people?

P: errrm that they get scared up. When I first told my boyfriend he was physically sick...(laughs)

I: right

P: so it was like ok errm that didn’t go down to well so...yes

I: yes I was gonna say its not just a fear of how people will react but people have reacted like that

P: yeah yeah definitely so errm yeah
I: so you said earlier at the moment you’ve got a shunt, which I believe drains doesn’t it?

P: yeah yeah

I: okay so when was that fitted?

P: errm that was fitted when I errm I was three, but I had about twelve shunt revisions so I had brain surgery errm about twelve times until I was ten..

I: right

P: and since then it's been alright touch wood so errm I just live in the moment know hoping nothing goes wrong

I: so when you say things are alright now that implies that you’ve had quite a bit of hassle in the past, can you tell me a little bit about how that has effected you.

P: errrm basically every year I'd expect to go in hospital or errm what happens is I get a headache and then they get really severe and if the shunt isn't changed, it means the shunt is blocking, if the shunt isn't changed then something worse will happen like errm with the other ones I had a stroke or whatever because the fluid puts pressure on the brain.....

I: sure

P: errrm so I have to go in hospital, have it changed so like that’s major surgery or whatever so then usually im in, im sort of laid up in bed for I don’t know a couple of weeks, months whatever, I’ve been in a wheelchair and all that sort of thing..

I: right
P: so errm then basically that's how it goes and errm they sort of shave my head or whatever so I used to have to wear a hat to school so, its kinda weird, a beret I wore
(laughs)

I: classy

P: (laughs)

I: so I guess I'm wondering cos you say now you don't choose to tell people about it but people must have known when you were growing up about it

P: yeah but I didn't, like I say I didn't actually deal with that as my mum told the teachers and she told everyone that needed to know and errr there was one occasion when I went in hospital and it was obvious and I had a beret or whatever and errr the teacher, the head teacher whose a really nice bloke got the whole class together in a little room and he told them all about it and I was there so it was like, ok so I don't have to deal with it still although im sitting there im not actually talking about it so...
yeah

I: so it kinda sounds like the responsibility lies with your mum or professionals or authority figures or...

P: yeah yeah definitely so but I don't feel good about that, I feel like, I don't know, I want to take charge I wanna be able to talk about it so....

I: yeah is it something about the way people react that stops you.

P: errrm well, basically ive never seen their reactions apart from ***** errrm I've never seen errr like I say my mums dealt with the teachers I've never heard what theve had to say about it how they thought it was a problem, so errm I would have like to have known.

I: sure. So in terms of your relationships with the kids at school did it make a difference there, was it mentioned or...
P: I knew they knew about it but they never mentioned it to me and I never mentioned it so..

I: why?

P: it was just one of those things you never talk about

I: sure

P: so errrr, I don’t know errrr I was confronted once with someone at errrm errrm middle school and she said to me oh you know I was always scared of you and I was like why so but that, that was really interesting to know because I didn’t know that

I: I had a question and its just gone..

P: that’s okay.

I: yeah so it it seems like a coping strategy for you has been just not to talk about it with people because of whatever might happen..

P: yeah yeah

I: do you think you have tried to deny it to yourself as well or do you think not?

P: errrr I think I have actually. My mum’s always told me you cant do this because of this, you know you’ve got this problem because of this and I'd be like no I've not I'm normal. No errrr but as time has gone on errrm like errrm the other the other I think it was, actually two weeks ago errrm I went into the computer room and I just decided to look it up like my disability errrm and I came across a web site and all the symptoms all the things you have to deal with were actually down there in black and white and I was like oh my god they know me....

I: yeah yeah
P: and it was really strange and I was like my mums always said be careful of this be careful of that, don't do gymnastics don't do this don't do the other and I've been like that's just mum being overprotective -

I: sure

P: but it was actually down there from a doctor and all these people so I was like, ok, that made, that made me feel better knowing someone else, someone professional errr actually said those things

I: um sure

P: so,

I: and also cos I mean that makes me think that you've never met anyone else with the same thing or never sort of..

P: erm I had a friend once but she was only a friend because she had it...

I: right

P: as it were errr like the parents were friends, her mum and my mum erm and erm she had the same thing but hers was much more severe she, so err, I don't know she was more, wasn't so much with it as it were, she had learning disabilities and things like that so errr I so I couldn't really associate it, associate it with her as such.

I: yes

P: so errr but it was good to know that someone else, but now I find like when I was looking on the internet I want to know about older people that have got it, like people who have got children, so I want to know how that's effected them and how it will effect me in the future
I: yeah, sure, sure. So do you think that gives you a sense of sort of group with these people or do you not see it in those terms?

P: errrm I don't know errrm I would like to know more people that have errr dealt with it errrm but I don't know, do I identify with them or not I, yes I suppose I do so..but as I say in a hidden sort of way, in my private space so

I: sure, sure errrm would you describe yourself as disabled

P: errrm I would purely for the fact that errr it makes life easier (laughs)..

I: right

P: as in I get a disabled badge err so it makes it easier parking (laughs) and things like that, so and also errr like with extra time, I get extra time in exams because of my stroke and that so for those reasons I would say it yeah...disabled...I wouldn't say, I'd say it was just a hidden disability yeah I am disabled but not physically sort of...

I: so you kinda take the label kinda because of the way the legal system works if you want to get any of the support or the facts or whatever....

P: exactly, what I need to make me normal as it were errr but then once I've got those I wouldn't say I was disabled

I: so you wouldn't describe yourself like that to friends or teachers or anything..

P: no I wouldn't say I was disabled I'd say I have a disability

I: right, ok
P: but I'm not disabled.

I: I guess I wonder if you see you have anything in common with people with different types of physical impairments
P: can you say that again, sorry

I: well, okay well what I've been reading in the literature is errr a lot of the sort of forefront errr work on disability and disability rights looks at how errr in order to sort of have a group to move society forward and make it less discriminatory they see you sort of have to have this disabled identity so almost like a disabled culture of err, in order to then move things forward errr but I'm wondering whether that is actually the experience of people so I suppose I'm wondering whether you think you have any kind of sense of community with other people with disabilities or whether you just see it as a lot of different people

P: errm I'm not sure about that, can I think about that for a minute...

I: of course

P: errrrm can you repeat it to me just one more time..

I: well it's the theories that say that in order for sort of errm disabled people to be less discriminated against we kind of need to get together in a big group like a community across all the disabilities and they kind of see that as the only way of improving society errr but what im wondering is actually disabled people do have that sense of community

P: errm I don't feel no I think everyone's unique I think you know errr that's part of you as a person but it does make you part of a group so I think everyone should be dealt with individually and not like lump people together they've all got disabilities, do you know what I mean errrm I always used to go to this errrm ************** adventure playground and there were people with disabilities there and obviously they were more severe than what I was and I couldn't identify and I was like I can't identify with this group of people I I I just wanna I wanna be put in a group with errrm I don't know with everyone accepted each other and your not labelled sort of thing, if they've got disabilities theve got disabilities but this was specifically for people errrm who obviously couldn't feed themselves, couldn't you know....
I: right okay, and you went along there because of err.

P: well my mum thought it would do me good to see other children with it but it was more severe and err, I don't know I just couldn't stand it to tell you the truth I used to sit there like at dinner times and it used to be terrible, I was just like I just cant eat, I'm just I can't do this, it was weird because errrm I was sort of one of the helpers more or less because I learnt sign language that sort of thing and I was going round like doing that sort of thing and that's how I saw it and I even went back there and did some work experience but errr errr I didn't like it to be like that like all grouped together, you go out in group, errr I just didn't like it.

I: because is there something about if people label you in that way there presuming you can't do a whole bunch of stuff that you can is there something around that...

P: yeah, yeah, definitely, yeah, and also I start thinking that and I don't like to think that. I like to think I can do it not oh I've got this I've got that, oh I better be careful. I like to think you know go out there get it, if something happens that you come up against then deal with it. So...

I: so sort of figuring it out for yourself not taking what other people tell you...

P: yeah, not starting from I've got a disability sort of dealing with life usually and then if you come up against something then you know, then realise why that is...sorry

I: so it sounds like your disability or however you want to call it is sort of somewhere there as part of you but its not a hugely important part, its its not as important as being a student or a ******** or...

P: no, no

I: any of those things.

P: no...well I dunno its sort of, it does make it that's why I want to do this, this is why I'm at university because errm I bet it pushes me, no ones like, nobody's going to label
me I'm going to do my best sort of you know, even better then like what people would presume so ... and it was really strange cos when it was my GCSE time I errr went for my results and I was like oh I've got F's or whatever and I got some really good grades and I was like why did I think that why, why was that in my head why did I think I was gonna fail everything you know..

I: yeah yeah so on one hand it sounds like its made you more determined.....maybe those voices have gone in that say you can't you can't you can't

P: yeah exactly and while there saying that im fighting against it and im going I can, I'm gonna do this so err definitely

I: but do you think it has made it harder to come and achieve the things you’ve achieved do you think it does affect your life at the moment

P: errr has it made it harder errr errr socially I think it does, I find it harder to errr form relationships with people because I feel errr I'm keeping something from them...

I: sure

P: so errr in that way socially yeah but not er educationally or anything like that

I: I can’t really think of anything else I need to say is there anything else you would like to add.

P: errrr

I: any areas you think we haven't covered or..

P: not really (laughs)

I: yes

P: yes okay
Exploring self-silencing amongst disabled people

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Abstract

This research explored whether disabled people are 'self-silencing' regarding their experiences of being disabled and investigates some of the factors that may affect such silencing. This was done using a questionnaire which measured level of self-silencing as well as degree of identifying oneself as disabled, identifying with a disabled group membership, perceiving that others avoid discussing disability, others' representations of disability and level of impairment. A statistical analysis was conducted to find any significant correlations in the data. In addition multiple regressions were run in order to investigate any potential predictors of self-silencing as well as considering whether age and gender had a moderating effect. This found that level of impairment and the perception that others avoid discussing disability were the main predictors of level of self-silencing. These findings are discussed along with other correlations between subscales as well implications for future research. Finally it was considered how the findings may relate to the experiences of disabled people, specifically reflecting upon the implications this may have for the field of Counselling Psychology.
Biographical Details

I am a twenty-seven year old disabled person. I have a degenerative eye condition which means I have been registered blind since the age of twenty-one. This research was undertaken as part of my doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. I chose to train as a Counselling Psychologist as its epistemological stance encourages a critical exploration of traditional psychological theory and practice. This training also enables me to practice as a therapist. My keen interest in the Disability Movement led me to undertake research pertaining to the experiences of disabled people. This research aimed to address some of the areas previously under researched within psychology.
Exploring self-silencing amongst disabled people

Introduction

This research aims to explore some of the factors that may affect levels of self-silencing regarding experiences of disability amongst the participants, all of whom had physical impairments. This builds upon Supple's (2002) research, which found that participants (who had a variety of physical impairments, see appendix A) felt restricted in how they could talk about their experiences of disability. This was a qualitative study which focused upon listening to disabled people's voices regarding how they spoke about their identities, and attending to how their disability may interact with this. This included a consideration of a disabled individual or group identity. The research found that the participants' voices served to silence their experiences of disability; instead, they spoke about how they hide or minimise their physical impairments. This seems to be similar to the concealment Shakespeare (1996) discusses as a coping response used to deal with disability. The minimisation of disability found in Supple's (2002) research, combined with how the participants rejected an individualised disabled identity and distanced themselves from membership of a disabled group seemed to imply that the participants did not integrate their disability into their sense of self. This could be perceived in terms of 'psychological disengagement', which Major and Schmader (1998) suggest is used by people who experience negative stereotypes, prejudice and discrimination, in order to maintain self-esteem. Thus, it is suggested here that self-silencing may be a coping strategy for dealing with the negative representations traditionally associated with disability (Abberley, 1987; Burman, 1994; Oliver, 1996). This research aims to investigate if the silence regarding one's disability found in Supple's (2002) research is present in a larger population, as well as considering what factors may affect this.

The concept of self-silencing has been used to explore other issues such as eating disorders (for example Geller, Cockell and Goldner, 2000), gender issues (Brown and Gilligan, 1993; Duarte and Thompson, 1999; Hall, 2000) and sexual abuse (Banyard, Arnold and Smith, 2000). Jack (1991) developed a theory of self-silencing amongst women with depression. She asserts that the internalised values of a woman's culture
act as an internal voice, which chastises or permits certain actions. She went on to
develop a scale called 'the silencing the self scale' (STSS) which has been used in
several studies (for example Ali, Toner, Stuckless, Gallop, Diamant, Gould and
Vidins, 2000; Page, Stevens and Galvin, 1996; Spratt, Sherman and Gilroy, 1998).

This research considers how self-silencing may be used by people who are given the
label of 'disability' in order to protect themselves from the associated negative
stereotypes. Sutherland (1981) asserts that there are many, often incompatible
stereotypes regarding disability, ranging from a presumption that disabled people are
helpless, bitter and mentally retarded, to being endowed with mystical powers. He
states that the thing they all have in common is that they serve to emphasise how
disabled people are different from other people. Burman (1994) asserts that the
discipline of psychology has contributed to the construction of a dichotomy of normal
and abnormal, defining disabled people as the latter. This has led to disability being
historically viewed as tragic and negative (French Gilson and Depoy, 2000) as well as
being associated with undesirable mental and moral qualities (Burman, 1994). Such
negative associations mean that disabled people, both individually and as a group,
have become stigmatised (Goffman, 1963; Susman, 1994). Devine (1989) suggests
that such negative stereotypes are widely disseminated and thus are familiar, even to
those who do not agree with them, as well as those who are the subject of them
(Steele, 1992). Thus, the participants in Supple's (2002) research may have been
rejecting such stereotypes when choosing not to identify themselves as disabled. It
may also be related to why they sought to distance themselves from other disabled
people, i.e. an attempt to avoid the stigma that may derive from being associated with
such a group. In work undertaken investigating identity conflict, Craig, Craig,
Withers, Hatton and Limb (2002) found that the participants (who had intellectual
disabilities) distanced themselves from others with intellectual disabilities. They
suggest that this could have been a way of avoiding the stigma associated with such a
group membership. Similarly, Finlay and Lyons (1998) considered the link between
self-concept and social identity with participants with learning disabilities. Although
they found that how the participants evaluated the label of 'learning disabled' was not
linked to their overall self-esteem, they did find those who did not identify with the
label felt more competent.
Tajfel's (1986) social identity theory argues that people strive for positive social identities in order to sustain self-esteem. He asserts that part of our self-concept is derived from our group memberships (he calls this 'social identity'). Ellemmers (1993) asserts that membership of a high status group leads to a positive self-identity, and conversely, Swim and Stangor (1998) suggest that someone who occupies a group which is attributed with a stigmatised identity will have a lowered self-esteem if internalising such representations. This may be further understood by Sutherland's (1981) assertion that one of the most common stereotypes regarding disability is to exaggerate a disabled person's level of impairment, attributing to all members of a disabled group a similar, highly impaired level of functioning. Therefore, self-silencing regarding one's disability may serve to distance oneself from such representations, enabling a person to reject disability as a label, as well as avoiding identifying with other disabled people. This would be supported by Tajfel's (1986) suggestion that a person may try and leave a group if it is deemed to provide a negative identity. However, a disabled person is unlikely to be able to leave the group by removing their impairment. Nevertheless, they may choose to minimise, hide or downplay their impairment, or to disidentify on a psychological level.

The type and level of one's impairment may have a profound impact on not only a person's experience of disability but also how they are able to talk about it. It should be acknowledged here that 'disability' covers a plethora of physical states and a variety of lived experiences. Thus, the nature and consequences of one's impairment may have implications regarding self-silencing. This was suggested by Supple's (2002) finding that some impairments, such as those that affect the reproductive system, are less acceptable to talk about. Also, those with a less visible disability may feel better able to silence themselves as they may have more of a choice about whether to disclose regarding their disability (Friehe, Aune and Leuenberger, 1996). Furthermore, levels of self-silencing may be affected according to how different types of impairment are perceived by others. That is, certain impairments are more socially acceptable than others (Tringo, 1970; Westbrook, Legge and Pennay, 1993; Wilton, 1998, 2000). Therefore, how socially acceptable a disability is may affect the degree of stigma associated with it, as well as strengthening the taboo surrounding it. Thus, it
may need to be considered how others’ attitudes regarding whether disability should be discussed may also affect how a person silences themselves. Also, level or type of impairment may have a bearing on how much contact a person has with medical professionals and institutions, which may affect the discourses available to them (Shakespeare, 1997; Simons, 1992).

These ideas concerning how self-silencing may be linked to disability were used to formulate the hypotheses underpinning this research:

1. There will be a higher level of self-silencing in those who do not adopt an individualised disabled identity.

2. There will be a higher level of self-silencing in those who distance themselves from membership of a disabled group.

3. There will be higher levels of self-silencing in those who perceive that others avoid discussing disability.

4. Levels of self-silencing will be higher in those who perceive that others hold negative representations of disability.

5. Levels of self-silencing will differ between categories (i.e. type) of impairment.

6. Levels of self-silencing will be affected by level of impairment.

A questionnaire was constructed in order to test these hypotheses. This aims to provide a starting point from which to explore how disabled people can talk about disability, by looking at self-silencing as well as factors that may have an impact upon this. It is important for research to consider what has been silenced in relation to disability, as this may relate to what has been under-researched in the field. Disability has been differentiated from physical impairment and defined as a cultural/social identity, which stems from a socially devalued and disempowered position.
(Shakespeare, 1993). It has been suggested that it has received little attention when compared to other comparable groups such as gender or race (Abberley, 1987).

This paper will argue that self-silencing may be of particular significance to the field of Counselling Psychology. This is due to several factors. Firstly, psychology as a discipline plays a central role in the diagnoses, treatment and rehabilitation of disabled people (Burman, 1994). Furthermore, Supple (2001) reviewed psychological literature regarding disability, published between 1999 and 2001, and concluded that the research was biased towards a medicalised model (Barton, 1996). It was also found that the literature disproportionately focused upon certain populations, e.g. the elderly or those in residential care, as well as predominantly being undertaken by non-disabled medical or psychological professionals. Such findings may be related to Shakespeare's (1997) assertion that psychology, as a discipline, is unaware of social explanations of disability. He asserts that psychology often adheres to traditional models and overlooks contextual and experiential issues. This should be of concern to Counselling Psychology because of its emphasis on the role of relationship and experiential and subjective knowledge. Also, therapeutic work is based upon communication and therefore self-silencing must be of concern to all therapeutic practitioners.

Method

Participants

A power analysis was run to ascertain how many participants should be included in this study (Erdfelder, Faul and Buchaner, 1996). This test recommends a sample size that will reduce the probability of making a type II error, i.e. retaining the null hypothesis when it is false. This recommended that 101 participants should be included. The final sample size was 100. The research recruited participants who considered themselves to have a disability. This included those who do not use this term to indicate a disabled identity but who recognise that they have a physical impairment that impacts upon their life. This aimed to include people with a diversity of impairments and to help consider the issue of whether the type and level of one's
disability impacts on levels of self-silencing. Also, this broad definition aimed to
avoid only attending to a stereotypical perception of disability, i.e. wheelchair users
(Sutherland, 1981). The research did not include people with mental health issues or
learning disabilities as this may have made the group overly diverse. The sample
comprised 47 men and 53 women, ranging in age from 16 to 87 years (mean = 51.59,
SD = 18.13). However, although a variety in ethnicity was sought, this was lacking
(see Table I). This may be due to the fact that the research was conducted mainly in
an area populated by white people.

Table I. Self-reported ethnicity of participants

<table>
<thead>
<tr>
<th></th>
<th>Asian</th>
<th>French</th>
<th>White - European</th>
<th>Australian</th>
<th>Indonesian</th>
<th>White British</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of participants</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>93</td>
</tr>
</tbody>
</table>

The collection of the data

Before any potential participants were contacted ethical approval was obtained from
the University of Surrey's advisory committee on ethics (see appendix G). Participants
were contacted via specific impairment groups e.g. Surrey association for
visual impairment, as well as locally run clubs and through Internet discussion lists.
Many of these contacts led to snowball sampling, whereby details of the research
were passed on to friends of original contacts. Potential participants were sent an
information sheet (see appendix B) in an appropriate format (e.g. electronic, large
print or hard copy). This described what the research was about, what participation
entailed and what would happen to the information after it was collected. Attached to
this was the questionnaire (see appendix C). It was then up to each person
individually to decide if they wished to complete and return the questionnaire (in the
envelope provided), as they received no further contact. It was made clear that
participation was completely voluntary. Thus there was no formal consent form;
instead, the completion and return of the form was used to indicate consent.
Confidentiality was maintained as no names or addresses appeared on the completed
questionnaires. The information sheet included contact details for disability organisations as well as other sources of support, which could be contacted if completing the questionnaire was in any way distressing.

The design of the questionnaire

The data were gathered using a questionnaire designed specifically for this research, which took approximately 20 minutes to complete. It is composed of 46 items, which form six subscales, listed below with example questions (see Figure 1). The first five subscales were rated on a 5-point scale ranging from 'strongly agree' to 'strongly disagree'. The last scale, which measured level of impairment, was rated on a 5-point scale ranging from 'none' to 'extreme/can't do', which indicated how much difficulty the participants had completing each activity.

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Self-silencing
11. I rarely speak about my disability

Identification of oneself as disabled
15. It is important to me to refer to myself as a disabled person.

Identification with 'disability' as a group membership
20. I do not fit in well with other disabled people.

Perception of whether others avoid discussing disability
25. I feel others prefer it if I do not discuss my disability.

Perception of how others regard disability
29. Most people think disability is tragic.

Level of disability
36. Taking care of your household responsibilities.

---

Figure 1. Example items from the questionnaire
The self-silencing sub-scale drew upon Jack's (1991) silencing the self scale, which was adapted for this research. The adapted scale comprised 12 items, as opposed to Jack's 31-item scale. Also, Jack's scale focused upon intimate relationships, conflict and emotions, whereas the scale used in this research focused upon communicating about one's disability or one's feelings. The 12-item Self-Administered Version of the World Health Organisation's Disability Assessment Schedule 2 (WHODAS II, 2001) was adapted in order to construct the sub-scale measuring level of impairment. Only questions pertaining to specific activities were used and some wording was altered so as to refer specifically to physical impairment. The other four sub-scales were developed in collaboration with two social psychologists drawing upon Supple's (2002) qualitative study. The questions included were constructed according to contemporary psychometric principles (Oppenheim, 1992). The questionnaire also gathered information regarding type of disability, age, gender and ethnicity.

A pilot study was undertaken in order to assess the questionnaire. An initial ten questionnaires were sent out with additional feedback sheets. The feedback indicated that participants found the questionnaire easy to understand and answer. However, some found the 'tick box' style of answering restrictive but, on further discussion, this seemed to reflect dissatisfaction with quantitative research more generally. Therefore, a section was added at the end of the questionnaire inviting participants to add any comments. When considering these comments a thematic analysis was undertaken. That is the participant comments were organised into themes, which are summarised at the end of the results section.

The analysis of the data

The data were compiled and analysed using the Statistical Package for the Social Sciences (SPSS). Any incomplete sets of data were excluded. Negative statements were reversed in order to ensure all questions were scored in the same direction, therefore a high score implied; a high level of self-silencing, a low level of identification with disability as an identity, a low level of identification with disability
as a group membership, a greater perception that others avoid discussing disability, a
greater perception that others perceive disability as negative and a higher level of
impairment. Types of impairment were then categorised into the following:

1. Mobility impairment, e.g. amputees, Spina Bifida, and spinal injury etc.
2. Sensory impairment, e.g. visual or hearing impairment.
3. Degenerative disability (neurological or physical) e.g. ataxia, MS, Parkinson's,
   post-polio syndrome, arthritis, multiple organ atrophy etc.
4. Chronic illness e.g. post-stroke, endometriosis, ME/CFS, osteoporosis, cancer etc.

Firstly, an ANOVA was carried out in order to test if there were statistically
significant differences in levels of self-silencing according to category of disability.
Correlations were then run in order to test whether each variable measured by the sub-
scales were related to level of self-silencing (this also indicated how the sub-scales
were related to each other). Further, ANOVAs were run in order to consider whether
age and gender had a bearing on these correlations. Multiple regressions were then
conducted in order to ascertain how the variables interacted and to establish the main
predictors of self-silencing. Finally, multiple regressions were used to consider what
factors had a moderating effect on such predictors.

Reliability coefficients were conducted in order to consider the internal reliability of
each sub-scale of the questionnaire. This tested the items in each sub-scale and
verified that each subscale performed as a coherent measure of the variable it
pertained to. Figure 2 shows the alpha co-efficients for each sub-scale (for further
details see appendix D). As this is a novel questionnaire its validity is yet to be
ascertained. Nevertheless, the variables in the questionnaire were drawn from
previous research regarding disability and thus are grounded in the experiences of
disabled people.
<table>
<thead>
<tr>
<th>Name of sub-scale</th>
<th>Alpha coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-silencing</td>
<td>.8584</td>
</tr>
<tr>
<td>Identification of oneself as disabled</td>
<td>.8192</td>
</tr>
<tr>
<td>Identification with 'disability' as a group membership</td>
<td>.8217</td>
</tr>
<tr>
<td>Perception of whether others avoid discussing disability</td>
<td>.7817</td>
</tr>
<tr>
<td>Perception of how others regard disability</td>
<td>.6197</td>
</tr>
<tr>
<td>Level of disability</td>
<td>.8154</td>
</tr>
</tbody>
</table>

**Figure 2. Reliability coefficients for each sub-scale**

**Results**

Before carrying out the statistical analysis, histograms were plotted to ensure that the data were normally distributed in order to establish which statistical tests were appropriate. All of the subscales showed a normal distribution, although the scale measuring how one identifies with a disabled group was slightly negatively skewed, which implies that more people were scoring at the lower end. However, this was not highly skewed, so parametric tests were used for the analysis.

The hypothesised link between type of impairment and levels of self-silencing was investigated using an analysis of variance (ANOVA). The four categories of impairment were compared, i.e. mobility impairment (n = 26), sensory impairment (n = 29), degenerative disability (n = 23) and chronic illness (n = 22). See Table II for means and standard deviations of each category.
Table II. Means and standard deviations for self-silencing scores by type of impairment

<table>
<thead>
<tr>
<th>Impairment Type</th>
<th>Mobility Impairment (n=26)</th>
<th>Sensory Impairment (n=29)</th>
<th>Degenerative Impairment (n=23)</th>
<th>Chronic Illness (n=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of self-silencing (12-60)</td>
<td>36.12 (11.84)</td>
<td>32.07 (11.52)</td>
<td>37.35 (9.36)</td>
<td>40.05 (11.06)</td>
</tr>
</tbody>
</table>

Key = mean (Standard deviation)

No significant overall difference between levels of self-silencing according to category of disability was found (F(3,96) = 2.320, p = NS). Although the overall analysis was not significant, it should be noted that a post-hoc pairwise comparison indicated that there was a significant difference between those with sensory impairment and those with a chronic illness (p< .05). In addition, Figure 3 (which plots the mean self-silencing scores of each disability category) shows that participants with a sensory impairment (mean = 32.07) also scored lower than both those with a mobility impairment (mean = 36.12) and those with a degenerative disability (mean = 37.35), as well as those with a chronic illness (mean = 40.05).
Given the relatively small numbers in each group, this finding implies that further work with bigger samples is needed to explore such differences in order to further test hypothesis 5, i.e., levels of self-silencing will differ between categories (i.e. type) of impairment.

**Correlations**

Correlations were conducted to explore whether there was a relationship between levels of self-silencing and the other variables measured by the questionnaire, i.e. identifying oneself as disabled, identifying with a disabled group membership, perceiving that others avoid discussing disability, others' representations of disability and level of impairment. Table III shows these correlations.

**Table III. Correlation co-efficients between self-silence and other sub-scales**

<table>
<thead>
<tr>
<th></th>
<th>Self-silencing</th>
<th>Identifying oneself as disabled</th>
<th>Identifying with group</th>
<th>Perception others avoid discussing disability</th>
<th>Others' representations of disability</th>
<th>Level of impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-silencing</td>
<td>1</td>
<td>.140</td>
<td>.112</td>
<td>.379**</td>
<td>-.052</td>
<td>.246*</td>
</tr>
<tr>
<td>Identifying oneself as disabled</td>
<td>.140</td>
<td>1</td>
<td>.258**</td>
<td>.122</td>
<td>-.208*</td>
<td>-.243**</td>
</tr>
<tr>
<td>Identifying with group</td>
<td>.112</td>
<td>.258**</td>
<td>1</td>
<td>.127</td>
<td>-.151</td>
<td>-.210**</td>
</tr>
<tr>
<td>Perception others avoid discussing disability</td>
<td>.379**</td>
<td>.122</td>
<td>.127</td>
<td>1</td>
<td>-.025</td>
<td>.220*</td>
</tr>
<tr>
<td>Others representations of disability</td>
<td>-.052</td>
<td>-.208*</td>
<td>-.151</td>
<td>-.025</td>
<td>1</td>
<td>-.001</td>
</tr>
<tr>
<td>Level of impairment</td>
<td>.246*</td>
<td>-.243**</td>
<td>-.210**</td>
<td>.220*</td>
<td>-.001</td>
<td>1</td>
</tr>
</tbody>
</table>

Key. * = Correlation is significant at the 0.05 level, ** = Correlation is significant at the 0.01 level
This shows that self-silencing was significantly positively correlated with the perception that others avoid discussing disability and level of impairment. There were no other significant correlations with the other sub scales. This appears to provide some evidence to support hypothesis 3 (there will be higher levels of self-silencing in those who perceive that others avoid discussing disability) and hypothesis 6 (levels of self-silencing will be affected by level of impairment).

Correlations were also found between sub-scales. That is, identifying oneself as disabled is positively correlated with identifying oneself with a disabled group membership but was negatively correlated with other representations. Both identifying oneself as disabled and identifying with a disabled group was negatively correlated with level of impairment. This implies that the higher the level of impairment, the more likely it is that someone will identify themselves as disabled or identify with a disabled group membership. Finally, there was a significant positive correlation between the perception that others avoid discussing disability and level of impairment. Further separate correlations were conducted for each impairment category, age group and gender (see appendix E).

Age and gender

An ANOVA was conducted to establish if gender (see Table IV) and age (see Table V) may affect levels of self-silencing. This did not find any significant effects according to gender (F(1,92) = 2.041, p = NS) or age (F(3,92) = .435, p = NS). Although information had also been gathered on ethnicity, there was not enough diversity to use it as a variable.

Table IV. Means and standard deviations for self-silencing scores by gender

<table>
<thead>
<tr>
<th></th>
<th>Women (n=53)</th>
<th>Men (n=47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levels of self-silencing</td>
<td>37.58 (10.03)</td>
<td>34.4 (12.4)</td>
</tr>
</tbody>
</table>

Key = mean (standard deviation)
Table V. Means and standard deviations for self-silencing scores by age group

<table>
<thead>
<tr>
<th>Age group</th>
<th>Level of self-silencing</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 35 (n=22)</td>
<td>36.77 (12.68)</td>
</tr>
<tr>
<td>35 - 49 (n=25)</td>
<td>35.44 (10.25)</td>
</tr>
<tr>
<td>50 - 64 (n=29)</td>
<td>34.55 (11.83)</td>
</tr>
<tr>
<td>&gt; 65 (n=24)</td>
<td>38.00 (10.58)</td>
</tr>
</tbody>
</table>

Key = mean (standard deviation)

Multiple regression

A multiple regression was carried out with the five subscales (i.e. identifying oneself as disabled, identifying with a disabled group membership, perceiving that others avoid discussing disability, others' representations of disability and level of impairment) as predictors and self-silencing as the dependent variable. The linear combination of these five predictors was significantly related to level of self-silencing (R squared = .20, adjusted R square = .15, F(5,94) = 4.686, p< .05). As expected from the correlations, the sub-scales found to be significant predictors were the perception that others avoid discussing disability (beta = .300, p< .05) and level of impairment (beta = .231, p< .05).

Moderation effects

Further multiple regressions were conducted for each category of impairment in order to investigate if the type of impairment moderated these relationships. A multiple regression was conducted with the five sub-scales as predictors for participants with a degenerative disability. The linear combination of these five predictors was significantly related to self-silencing (R squared = .610, adjusted R square = .495, F(5,17) = 5.313, p< .05). The significant predictor here was the sub-scale relating to identifying with a disabled group (beta = .508, p< .05). Similarly, this implies that a change in score on the scale relating to how strongly a person identifies with a disabled group membership will be related to how someone scores on the self-
silencing sub-scale. Significant effects of the combination of predictors were not found for any of the other categories of impairment, i.e. mobility impairment (R squared = .15, adjusted R square = -.05, F(5,20) = .732, p = NS), sensory impairment (R squared = .18, adjusted R square = .00, F(5,23) = 1.024, p = NS) and chronic illness (R squared = .45, adjusted R square = .28, F(5,16) = 2.671, p = NS). However, it should be noted that carrying out multiple regression on individual groups would only have detected large effect sizes due to the small numbers (i.e. all of the disability categories had less than 29 members). Therefore, further research is needed which uses larger samples.

Multiple regressions were also conducted to consider if gender or age had a moderating effect on the relationship between self-silencing and the other sub-scales. This was because the original model of self-silencing developed by Jack (1993) was gender specific. This showed that when conducting a multiple regression with the five sub-scales as predictors, there was no significant effect for women (R squared = .069, adjusted R square = -.030, F(5,47) = .693, p = NS), but the linear combination of the sub-scales was significantly related to level of self-silencing for men (R squared = .364, adjusted R square = .286, F(5,41) = 4.694, p< .05). The predictor here relating to self-silencing score was level of impairment (beta = .371, p< .05).

Multiple regressions were conducted for each age group (with the five sub-scales as predictors), as Supple (2002) found that younger participants seemed to feel less able to discuss their disability than older participants. The linear combination of these five predictors was significantly related to level of self-silencing in participants below the age of 35 years (R squared = .517, adjusted R square = .366, F(5,16) = 3.427, p< .05), where the significant predictor was level of impairment (beta = .316, p< .05). Also, a linear combination of the sub-scales was found to relate significantly to level of self-silencing in those aged between 35 and 50 years (R square = .491, adjusted R square = .357, F(5,92) = 3.666, p< .05). The significant predictors here were one’s perception that others avoid discussing disability (beta = .419, p< .05) and identifying oneself as disabled (beta = -.413, p< .05); this was a negative correlation which meant that a high score on self-silencing is related to whether one identifies as disabled. Those aged between 50 and 65 years were also found to have a linear combination of sub-
scales significantly related to level of self-silencing (R square = .590, adjusted R square = .501, F(5,23) = 6.629, p< .05). The significant predictors here were identifying oneself as disabled (beta = .476, p<.05) and the perception that others avoid discussing disability (beta = .513 p< .05). No significant predictors were found for those aged over 65 years (R squared = .348, adjusted R square = .168, F(5,18) = 1.926, p = NS).

The participants' feedback

During the pilot study, participants commented that they felt restricted in the answers that they could give. As a result, a section was included at the end of the questionnaire inviting the participants to make any comments. This led to some interesting and important feedback, summarised here. Some of the participants expressed a concern that closed questions cannot take into consideration some of the contextual issues that may affect how they can speak about disability. For example, one participant wrote "talking about my feelings and referring to myself as disabled is totally different if it's a partner/close friend I can confide in, as opposed to if it's a stranger I've met socially (in which case I would avoid mentioning it as far as possible to avoid nosey questions). These things are totally different if dealing with an institution of some kind in order to arrange access or explain why I can't do certain things, in which case I would be as assertive as possible about my needs and not care about their personal reaction". Similarly, another participant reflected that "it's completely context dependant. With many health professionals I would feel that I would get my knuckles rapped if I acted disabled, with many of my wider acquaintances they would be shocked if they saw me in a wheelchair and if I was dating people I would conceal outward signs of my disability in the early stages at least, but in certain other situations the onus would be on me to act disabled e.g. at benefit reviews I would be highlighting my difficulties. It is so complicated that a tick box just can't begin to sum it all up". Another participant observed that when the questionnaire asks about 'others', the answer depends on who the 'others' are: "my colleagues were excellent but the management was incredibly bad and opened a new building totally ignoring its planning permission obligations to meet the needs of disabled people". Similarly, another person commented that "certainly I find a big difference between my new
friends, where my confidence has been affected and old friends where my relationship has been strengthened”. It was also mentioned that who the 'other disabled people' are also makes a difference, “so I think the questions about whether or not I identify with other disabled people is also too vague, as the term covers such a wide range of conditions. I strongly identify with people with disabilities/illnesses the same as, or similar to my own, but much less with someone with a learning disability for example because it's completely outside the range of my experience, as it would be for a non-disabled person”.

Another participant indicated that restrictions in how one can respond to research questions may alter how the participant feels about participating, commenting “I found the questionnaire very frustrating. It is very difficult to answer no or yes when asked a question where the answer depends so much on the situation you are in at the time”. The answers people were given to choose from seem to have had an impact on how the participants responded: “the options restricted my ability to answer. I think that the option, neither agree or disagree was helpful here because sometimes my answers were too complex to be described by either extreme. When I chose the neutral option it was because my answer was sometimes yes, sometimes no”. Similarly, one participant wrote “I thought I should comment on the difficulty I faced in answering your questions honestly as I thought sometimes the answers were dependant on different factors and I couldn't qualify my answers.” Also, it was highlighted that a person can have different aspects to their disability: “I draw a big distinction between the different parts of my disability and might answer the questions differently for those different parts”. Furthermore, some felt that the same questions do not necessarily apply to people with different disabilities: “I think the fact that my disability is invisible yet fairly severe makes it difficult to compare with other disabilities that you might be looking at, which are visible. Invisible disability or illness has its own set of issues and prejudices”.
Discussion

This research investigated what factors affected levels of self-silencing amongst the participants all of which had a physical impairment. The results confirmed hypothesis 3 (there will be higher levels of self-silencing in those who perceive that others avoid discussing disability), and hypothesis 6 (levels of self-silencing will be affected by level of impairment). That is, a higher level of impairment predicted a higher level of self-silencing. Category (i.e. type) of impairment was not found to have a significant effect on the level of self-silencing. Although there was no significant difference in levels of self-silencing according to gender, it was found that in men, a higher level of impairment predicted a higher level of self-silencing. In addition, predictors of levels of self-silencing were found to differ according to age group. That is, it was found that a higher level of impairment was the main predictor for those under the age of 35 years, whilst the perception that others avoid discussing disability and whether a person adopted a disabled identity were the main predictors of higher levels of self-silencing in those aged between 35 and 50 years, and a lower level of identification with a disabled group was a significant predictor of increased self-silencing for those aged between 50 and 65 years. No significant predictors were found for those over the age of 65 years. Other significant correlations were also found between sub-scales. That is, a lower level of identification with an individualised disabled identity was correlated with a lower level of identification with a disabled group membership and both of these were correlated with a lower level of impairment. In addition, the perception that others avoid discussing disability was also correlated with a higher level of impairment.

Therefore, there seems to be some evidence that the higher the level of impairment, the higher the level of self-silencing. It may be that those with a higher level of impairment are more likely to have a clearly visible impairment and Stone (1995) suggests that this group is more likely to be perceived as disabled. It may then follow that higher levels of impairment are associated with being 'more disabled' and thus perceived as less acceptable (Tringo, 1970; Westbrook et al., 1993; Wilton, 1998, 2000) and therefore are more likely to be attributed with the negative representations associated with disability (French Gilson and Depoy, 2000; Wright, 1960). Also,
Harper (1999) found that the more obvious a person's physical impairment, the more they were avoided and the less desirable they were perceived to be as friends. This may suggest that those with more obvious or higher levels of impairment had more reason to minimise or hide their disabilities. This is supported by Weiserb and Gottlieb's (2001) assertion that minimising the pervasive impact of a disability serves to improve social relationships. In addition, those seen as 'more disabled' may be more exposed to the hostility that Barker, Wright, Meyerson and Gonick (1953) suggest is shown towards disabled people, as well as the nervous and awkward reactions that Young (1990) suggests disabled people can provoke in non-disabled people. The finding that there was a significant positive correlation between level of impairment and the perception that others avoid discussing disability may imply that others are more likely to avoid discussing higher levels of impairment. There was no significant difference in level of self-silencing according to type of disability, although this may have been due to small sample sizes meaning only large effects were detected. However, the fact that there were some differences according to category of disability, coupled with the finding that level of impairment was a predictor for level of self-silencing amongst people with degenerative disabilities implies that further work is needed looking at differences between types of impairment.

It was also observed that level of impairment was significantly correlated with self-silencing in men and not women. This may imply that a higher level of impairment and associated representations conflict more with a stereotypical view of a man (Pollack and Shuster, 2001) than they do with a stereotypical view of a woman (Gilligan, 1982). In addition, it contradicts Jack's (1991) assertion that women are silencing themselves regarding their experiences.

When considering the link between levels of self-silencing and level of impairment, it should be considered that those with a higher level of impairment are likely to be more dependant on support services and have more contact with carers. Simons (1992) suggests that disabled people are reluctant to voice negative feelings towards those they are reliant on, in order to avoid conflict or disapproval. This may mean that certain types of communication are stifled within such contexts. Further work needs to be done to investigate whether levels of self-silencing are higher in those who are
most likely to have prolonged or regular contact with health professionals. In addition, a higher level of impairment may imply that disability affects more areas of one's life. Therefore, higher levels of self-silencing may be found in this group because the issue of one's disability is potentially more relevant more often, and thus there are more opportunities to self-silence.

However, there is another way of perceiving such silence. That is, rather than seeing it as an indication that disabled people are being stifled, it could be seen as a positive choice in order to maintain one's privacy. Braithwaite (1991) suggests that disabled people are routinely asked about their health, bodies, sexuality or feelings by strangers. She suggests that such questions may function to make non-disabled people feel less discomfort regarding disability whilst not necessarily increasing their acceptance of it. This seems to be supported by the participant who commented that they stayed silent about their disability in order to avoid nosey questions (see results section). However, to imply that self-silencing is a strategy to maintain one's privacy conflicts with the finding that high levels of self-silencing were correlated with the perception that others avoid discussing disability.

When considering how level of impairment affects people's behaviour, some discussion is needed regarding what 'level of impairment' means. Traditionally, measures of level of impairment have been based on daily activities (such as the WHODASII used in this research). However, Pfeiffer (1998) suggests that such measures reflect the social values of those who construct them, overlooking the diversity in experiences amongst disabled people. He suggests that this is not overly problematic if the measures are used to develop a picture of disability across a population, but that problems arise when they are used to assess benefits or allocate resources. Also, such measures do not take context into account. Thus, it should be considered that the participants might have scored differently on level of impairment if they had been asked alternative questions or on a different day. Also, such scales see the physical impairment as the cause of restrictions (Pfeiffer, 2000), which overlooks any social explanation of disability (Oliver, 1996).
The research also found that those who perceive that others avoid discussing disability have higher levels of self-silencing. This may imply that silence is used as a way of maintaining harmony. This is what Jack (1991) suggested underlay women's self-silencing. Here, it may imply that the participants are hesitant to break the taboo imposed by others. This may be in order to protect oneself from awkward or negative reactions from others (Wright, 1960), or to avoid either being exposed to or having to challenge the negative representations associated with disability (Sutherland, 1981). Chaudhuri (1999) suggests that disability provokes anxiety in the non-disabled, which leads to avoidance. Thus, this finding may show that self-silencing is used in order to avoid conflict or rejection. Further work may need to be done regarding whether or not disabled people perceive that society at large (including medical and psychological professionals) wishes to avoid discussing disability. If this is the case, society itself may be promoting self-silencing amongst disabled people. Jack (1991) suggests that it is hard for a person to sustain a challenge to a dominant discourse because of internalised norms, which Mead (1956) suggests is the form by which a community exercises control over the conduct of its individual members. However, it is necessary to investigate whether such taboos relate to disability in its entirety or if this only applies to certain types of speaking. That is, Supple (2002) found that it was less acceptable to discuss the negative aspects of one's experiences, whilst Sutherland (1981) suggested that positive stereotypes of being jolly and optimistic were encouraged.

An important part of understanding self-silencing may be to consider in more detail when it occurs. Some of the participants' comments implied that context may have a great impact (see results section) and that this may be more significant than whether a person identified themselves as disabled. Level of self-silencing was not found to have an overall link with whether a person identified themselves as disabled or whether they identified with a disabled group, although this was found to have an effect among those aged between 35 and 65 years. This may imply that age or generational values may affect one's sense of identity.

More research is needed to look at whether disabled people identify with the label of disability, in an individual or group sense. Also, more work needs to be done looking
at what representations of disability are held by disabled people. These may differ according to whether they are applied to oneself, to disability as a concept or to other disabled people. It seems to have been an oversight in this research that the participants were not asked how they perceived disability. This seems to be an underdeveloped area in the field, as much research tends to be based on non-disabled people's perspectives of disability (Supple, 2001).

It was also found that a lower level of identification with an individualised disabled identity was correlated with a lower level of identification with a disabled group identity. This may imply that if a person perceives disability as an undesirable label for themselves, they would also avoid others with the same label. Tajfel's (1986) theory of social identity would imply that such a rejection was a way of maintaining a positive self-esteem. Therefore, future research may be needed to look at whether such identification or disidentification with disability is related to levels of self-esteem. Also, the finding that people with lower levels of impairment were less likely to identify with an individual or group disabled identity may imply that those with lower levels of impairment are more able to distance themselves from disability and do not wish to be stereotyped as more disabled than they are (Sutherland, 1981). Equally, those people with a high level of impairment are more likely to identify with an individual or group disabled identity. Therefore, further research may be needed to explore if those with a high level of impairment adopt alternative strategies to the self-silencing or distancing oneself from disability that have been focused upon in this research.

**Limitations and suggestions for future research**

It needs to be considered whether disabled people are self-silencing regarding their physical impairment or their disability, as well as whether they have access to alternative discourses. Research may be needed to ascertain if disabled people are familiar with the social model as an alternative to the medical model. Furthermore, the choices regarding identity discussed here may be overly simplistic. It may be that a disabled identity is complex and multi-layered or not chosen as an identity at all,
which Shakespeare and Watson (2001) suggest is overlooked by medical and social explanations of disability. Future research may need to further clarify what a disabled identity means in order to explore diversity within this. Also, diversity in context as well as between and within different categories of impairments was not explored in this research, and thus it may have over-homogenised radically different experiences. Further research needs to consider how such factors may affect people's experiences of disability and how they can speak about them.

It should also be considered that using a pen and paper questionnaire limited what questions could be asked and how they were asked. That is, the participants may understand their silence in ways different to those offered in the questionnaire and the participant's comments implied that there were contextual factors that affected their answers that could not be included in the questionnaire (see results section). This may imply that qualitative research could help to investigate which contextual factors affect how disabled people speak about themselves. Also, it should be considered that how the data were collected will affect who participated. Questionnaires were provided either on paper or via e-mail. The former format may have discriminated against those who cannot read or write, whilst using the Internet raises its own issues (see Hewson, 2003), including who has access to it. However, care was taken to provide the questionnaire in a format that was accessible to each participant. The fact that the questionnaire focused upon 'speaking' also meant that those with communication difficulties were excluded. Finally, how participants were contacted may have had an impact on who participated. That is, many of the participants were contacted through disability groups, agencies or publications. Thus, only those who identified with disability organisations in some way would have been contacted.

Implications for Counselling Psychology

The final consideration in this paper is how this research may apply to Counselling Psychology. This is important for several reasons. All therapeutic practitioners will come into contact with disabled clients at some point in their careers, especially if adopting Zola's (1989) definition of disability. He suggests that disability will affect
all people at some stage either through illness, injury, congenital impairment or old age. The fact that psychology plays a central role in the assessment and rehabilitation of disabled people means that the issue of how disabled people can talk about their experiences is relevant. Thus, the implications of this research for Counselling Psychology need to be considered. Levels of self-silencing were found to be higher in those with a higher level of impairment and these are the people who are more likely to be cared for within the hospital system, coming into contact with psychologists. This is of concern, as such institutions and professionals have traditionally perpetuated the construction of disability as abnormal in opposition to normal (Burman, 1994; Shakespeare, 1996). Zola (1989) suggests that in, order to change representations, disabled people have to start challenging the institutions themselves. Shakespeare (1996) suggests that disabled people need to be allowed to build new stories for themselves about the meaning that disability has for them. However, this will not happen if disabled people are silencing themselves. Psychologists are in a position to help disabled people find a voice through their therapeutic work. Shakespeare likens the process of defining one's disabled identity to 'coming out'. Schwartzberg and Rosenberg (1998) suggest that therapists can avoid issues of sexuality when working with gay men who are 'coming out'. They suggest that social norms and expectations will serve to censor what is discussed in therapy. Similarly, the discomfort and awkwardness that some feel regarding disability (Wright, 1960) may censor what is said in therapy by the therapist, the client or both. Schwartzberg and Rosenberg (1998) suggest that therapy can be used to consider the choices to be made about how to develop one's identity. However, learning to find new ways of talking about self and disability may mean coming into conflict with societal norms and expectations. This may be of further concern when considering that the other main predictor of self-silencing in the research was the perception that others avoid discussing disability. This may make it hard for disabled people to find the space to construct new stories and meanings regarding their disability. This may be further impeded by the fact that for many years psychology has perceived a rejection of a traditional disabled role as denial (Wright, 1960) and that disabled people could not be helped therapeutically unless adopting the dominant perception of disability as tragic in order to grieve and move on (Asch and Rousso, 1985). Much psychological theory still perceives a disabled client's problems as stemming from their impairment,
rather than considering any social factors in any meaningful way (Asch, 1985; Lenny, 1993).

Thus, it seems of supreme importance that psychology and Counselling Psychologists as therapeutic practitioners should be aware of alternatives to the traditional negative view of disability, as well as the possibility that disabled clients may be silencing themselves regarding their experiences of disability. It may be that multiple identities need to be considered, allowing a client to explore all parts of themselves, including their disability from a variety of positions so as they can construct alternative discourses regarding disability in ways that are congruent for them and legitimised by others.

**Conclusion**

This research aimed to explore what factors affected levels of self-silencing amongst the participants, all of whom had a physical impairment. It found that a person's level of impairment, as well as their perception that others avoid discussing disability, predicted levels of self-silencing. This may imply that those who are perceived as 'most' disabled and who feel that others want to avoid discussing disability feel least able to speak about their experiences. It was also found that factors such as type of disability, gender and age had a bearing on the issue of self-silencing, although further work is needed in order to expand on this. It is concluded that there are many factors that affect self-silencing and that future research may need to consider contextual issues as well as the diversity of experiences that exist amongst disabled people. It may also be concluded that more research needs to be done in this field so that professionals working with disabled clients are aware of the choices available to disabled people when considering their identity, as well as how they may be silencing themselves regarding their experiences of disability.
Reflections on my use of self in the research

My research interests throughout my doctoral training have been shaped by my own experiences. That is, the fact that I am registered blind led me to focus upon disability, what defines it, surrounds it and constructs it, as well as how all of these things may impact upon disabled people. This led me to undertake a literature review that considered which constructions of disability and disabled people are inherent to contemporary psychological research. I concluded from this that psychology was missing disabled people's voices, instead focusing on medicalised aspects of impairment provided by medical or psychological professionals, rather than coming from disabled people themselves. I identified with this, feeling that I had lacked a voice as a disabled person, struggling to survive in a 'non-disabled persons' academic world. Thus, my second piece of research focused upon the voices of disabled people. This was emancipating because of what I learnt about social explanations of disability, as well as allowing the experiences of the participants to be held as central. This indicated that disabled people were often minimising their impairments, which included avoiding discussing their experiences of disability. This led me to focus upon self-silencing in this piece of research. However, I began this research with an increasing feeling of paradox. That is, my previous research had led me to conclude that the oppression disabled people encounter and which underlies their silence stemmed from traditional negative, individualised representations of disability. I perceive that these are constructed and perpetuated by traditional epistemological stances, based on a positivist paradigm, which creates dichotomies such as 'normal' and 'abnormal'. Undertaking quantitative research, which in many ways was symbolic of such a traditional position, made me feel that I had a difficult balancing act to perform, that is, to foreground the voices of the participants and the meanings they ascribe to disability, whilst also adhering to a traditional, positivist way of researching. Although any research has the potential to foreground the researcher's perspective and minimise the participant's perspective, I was concerned that this may be more easily done when using a quantitative method.

I was aware of how important it was to ensure the participants' own perspectives were given saliency in the research. This was because, as a disabled researcher, I wanted to
avoid replicating the traditional dominant discourses that I feel so many non-disabled researchers have perpetuated in their research. There was a certain amount of conflict inherent to this as I had a specific hypothesis I wanted to explore. Although I felt this gained legitimacy by the fact that I am an 'insider', and by the fact that I felt a certain sense of community with the participants, I was also aware that my own perspective could obscure the views of the participants just as much as traditional presumptions can. In addition, many of the participants showed much enthusiasm for the research, reflecting that they wanted to contribute to research that would help disabled people. This served to further reinforce how important it was for me to feel that I had respected and accurately represented the participants' views. It was here that I struggled with the idea that the pre-defined concepts and questions included in this research could facilitate this. Thus, I had to find a way of foregrounding the participants' views whilst also maintaining my own understanding of disability and disabled identity, as well as being able to undertake a quantitative piece of research with enthusiasm and congruence. I concluded that undertaking this quantitative research allowed me to explore some of the concerns I had first hand, rather than critiquing from the outside. Therefore, this research held importance and interest for me, although I struggled with many aspects of its epistemology. That is, despite feeling the subject it deals with is of great importance, I struggled with the idea that closed, tick-box questionnaires could address it. I partially addressed this by including some of the participants' own comments, whilst also trying to keep in mind when writing up this research the variety of perspectives I have encountered from disability research, as well as from my own relationships with other disabled people.

Although the statistical analyses yielded some interesting findings, I found it hard to engage with them or feel a sense of ownership regarding them. This may have been because part of me was relating to the data as a disabled person, seeing it as a privileged narrative used by academics, which in turn overlooks disabled people's experiences. Also, it may be that I reject quantitative methods because they symbolise what I am excluded from as a visually impaired person, both in terms of not being catered for by the institutions that favour such methods, as well as using tools that are inaccessible to me, such as statistical computer packages and pen and paper questionnaires. However, in turn, the researcher part of me did not want to dismiss
some interesting findings that could potentially lead to important future research. Thus, although I feel a certain amount of ambivalence toward this research, I also hope that I have been able to blend personal and academic perspectives to ensure that it is a valid piece of psychological research useful to professionals but based upon the experiences of disabled people. This research also helped me to recognise the importance of acknowledging what is appropriate for me. My therapeutic work and epistemological stance both focus on relational and phenomenological concerns, which may need to be reflected in any future research I undertake.
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INFORMATION SHEET.

This is to ask you if you would consider participating in some research that I am undertaking as part of my final year doctoral project. I am a counselling psychologist in training studying for a doctorate in psychotherapeutic and counselling psychology at the University of Surrey. I am exploring how disabled people talk about themselves regarding their experiences of disability. I am particularly interested in this area as I am disabled myself (registered blind). I also feel this is an important area for psychology to consider. This is because how psychology thinks about disabled people can influence current theory about disability as well as having an effect on the services provided for disabled people. This research also hopes to investigate whether disabled people's needs and experiences are being listened to and taken into consideration by the field of psychology.

What does it involve?

If you decide you would like to participate in this research, you will need to complete the attached questionnaire, which should take 15 to 20 minutes. This will involve answering some questions about your disability, how you feel about it and how you feel about talking about it. Once you have done so, place it in the provided addressed envelope and return it to me.
What happens next?

If you decide to fill out the questionnaire, once you have returned it you will have no further contact from me. As your name does not appear anywhere on the form, your anonymity will be maintained at all times. All completed questionnaires will be stored securely, in accordance with the Data Protection Act (1988) and destroyed after use. However, if you are interested in the finished research, you can contact me at the address below.

If you find answering the questions in any way distressing, you can find out about support in the local area through the organisations given below which provide information about disability related issues.

( N.B. If you live in a different area and would like information about disability groups, please contact me and I will do all I can to help).

Alternatively you could contact your local GP or counselling centre for additional support.

What will I do?

I will use the information from the questionnaires to run a statistical analysis, which will help me to look at patterns in the answers I receive. No individual answers will appear in the research, only the overall outcome. The findings will then be submitted as part of my doctoral portfolio. There is a possibility that at some point in the future it may be submitted to a journal for publication but this depends on the findings.

Thank you for your time.

Yours Sincerely,

Mrs. Sarah Supple.

Counselling Psychologist in Training.
CONTACT DETAILS.
You can either contact me or my supervisor (Dr. Adrian Coyle) with any queries at:
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Or via e-mail at either
psm6sg@surrey.ac.uk (for me)
Or a.coyle@surrey.ac.uk (for my supervisor).
Or you can ring and ask to be put through to the Psych. D Office on 01483 300800.

ORGANISATIONS.
There is a disability information service for the Surrey area, which can be contacted on the internet at www.diss.org.uk/intro.html. The phone number for information on DISS is 01306 875156 or minicom on 01306 742128. Their address is DISS, Harrowlands Centre, Harrowlands Park, Dorking, Surrey, RH4 2RA.
Also you can contact the Berkshire Disability Information network, on the internet at www.bdin.freeserve.co.uk. They can also be contacted on the phone on 01344 301572 or 01344 726500. You can also write to them at BDIN, Brackenhale School, Rectory Lane, Bracknell, RG12 7BA.
Appendix C

Thank you for answering this questionnaire, it should take 15 to 20 minutes. For each question mark the box that best describes your response.

The word 'disability' will be used to refer to your physical impairment in this questionnaire. Although some of you may choose not to use this word to describe yourself, it will be used to avoid confusion. If your disability is not specifically mentioned in a question, it means that question is asking about your life more generally.

1. I don't speak my feelings if I think they will cause disagreement.

   - Strongly agree
   - Slightly agree
   - Neither agree or disagree
   - Slightly disagree
   - Strongly disagree

2. I don't speak about my disability if I think it will cause conflict.

   - Strongly agree
   - Slightly agree
   - Neither agree or disagree
   - Slightly disagree
   - Strongly disagree

3. When other's needs and feelings conflict with my own, I always state mine clearly.

   - Strongly agree
   - Slightly agree
   - Neither agree or disagree
   - Slightly disagree
   - Strongly disagree
4. I feel I have to act in a certain way to please others.

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Slightly agree</th>
<th>Neither agree or disagree</th>
<th>Slightly disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>

5. I feel I need to act 'less disabled' to please others.

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Slightly agree</th>
<th>Neither agree or disagree</th>
<th>Slightly disagree</th>
<th>Strongly disagree</th>
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</thead>
</table>

6. Instead of risking confrontation, I would rather not discuss my feelings.

<table>
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<th>Neither agree or disagree</th>
<th>Slightly disagree</th>
<th>Strongly disagree</th>
</tr>
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</table>

7. Instead of risking confrontation, I would rather not talk about my disability

<table>
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<tr>
<th>Strongly agree</th>
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<th>Neither agree or disagree</th>
<th>Slightly disagree</th>
<th>Strongly disagree</th>
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</table>

8. I rarely talk about my feelings.

<table>
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<th>Slightly agree</th>
<th>Neither agree or disagree</th>
<th>Slightly disagree</th>
<th>Strongly disagree</th>
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</table>
9. I do not show my real self to others.

Strongly agree [ ]  Slightly agree [ ]  Neither agree or disagree [ ]  Slightly disagree [ ]  Strongly disagree [ ]

10. I feel that others do not know about my disability.

Strongly agree [ ]  Slightly agree [ ]  Neither agree or disagree [ ]  Slightly disagree [ ]  Strongly disagree [ ]

11. I rarely speak about my disability.

Strongly agree [ ]  Slightly agree [ ]  Neither agree or disagree [ ]  Slightly disagree [ ]  Strongly disagree [ ]

12. I feel free to discuss my disability with others.

Strongly agree [ ]  Slightly agree [ ]  Neither agree or disagree [ ]  Slightly disagree [ ]  Strongly disagree [ ]

13. I do not like to call myself disabled.

Strongly agree [ ]  Slightly agree [ ]  Neither agree or disagree [ ]  Slightly disagree [ ]  Strongly disagree [ ]

Strongly agree   Slightly agree   Neither agree or disagree   Slightly disagree   Strongly disagree

15. It is important to me to refer to myself as a disabled person.

Strongly agree   Slightly agree   Neither agree or disagree   Slightly disagree   Strongly disagree

16. I do not call myself disabled.

Strongly agree   Slightly agree   Neither agree or disagree   Slightly disagree   Strongly disagree

17. I do not think that my disability is an important aspect of my self.

Strongly agree   Slightly agree   Neither agree or disagree   Slightly disagree   Strongly disagree

18. I think my disability is an important aspect of my self.

Strongly agree   Slightly agree   Neither agree or disagree   Slightly disagree   Strongly disagree
19. I identify with disabled people.

Strongly agree  Slightly agree  Neither agree or disagree  Slightly disagree  Strongly disagree

20. I do not fit in well with other disabled people.

Strongly agree  Slightly agree  Neither agree or disagree  Slightly disagree  Strongly disagree

21. I feel uneasy with other disabled people.

Strongly agree  Slightly agree  Neither agree or disagree  Slightly disagree  Strongly disagree

22. I feel strong ties to other disabled people.

Strongly agree  Slightly agree  Neither agree or disagree  Slightly disagree  Strongly disagree

23. I feel I have something in common with other disabled people.

Strongly agree  Slightly agree  Neither agree or disagree  Slightly disagree  Strongly disagree
24. I feel I have nothing in common with other disabled people.

Strongly agree □ Slightly agree □ Neither agree or disagree □ Slightly disagree □ Strongly disagree □

25. I feel others prefer it if I do not discuss my disability.

Strongly agree □ Slightly agree □ Neither agree or disagree □ Slightly disagree □ Strongly disagree □

26. I think other people are interested in talking about my disability.

Strongly agree □ Slightly agree □ Neither agree or disagree □ Slightly disagree □ Strongly disagree □

27. I think other people will like me less if I talk about my disability.

Strongly agree □ Slightly agree □ Neither agree or disagree □ Slightly disagree □ Strongly disagree □

28. I think other people are willing to talk about my disability.

Strongly agree □ Slightly agree □ Neither agree or disagree □ Slightly disagree □ Strongly disagree □
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<th>Slightly Disagree</th>
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<td>Most people think disability is tragic.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Others think I am less able than I am.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Overall, disabled people are considered competent by others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Most people consider disabled people to be independent.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>In general, others respect disabled people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
34. In general, others think disabled people are unfortunate.

Strongly agree [ ] Slightly agree [ ] Neither agree or disagree [ ] Slightly disagree [ ] Strongly disagree [ ]

Now I would like to ask you some questions about how your disability affects you on a daily basis. This has a slightly different answering scale. Please could you think back over the last 30 days and answer these questions thinking about how much difficulty you had doing the following activities (for each question mark only one response).

35. Standing for long periods, such as 30 minutes.

None [ ] Mild [ ] Moderate [ ] Severe [ ] Extreme/can't do [ ]

36. Taking care of your household responsibilities.

None [ ] Mild [ ] Moderate [ ] Severe [ ] Extreme/can't do [ ]

37. Learning a new task, for example, learning how to get to a new place.

None [ ] Mild [ ] Moderate [ ] Severe [ ] Extreme/can't do [ ]
38. How much of a problem did you have joining in community activities (for example, festivities, religious or otherwise) in the same way as anyone else can?

None □  Mild □  Moderate □  Severe □  Extreme/can't do □

39. How much have you been emotionally affected by your disability?

None □  Mild □  Moderate □  Severe □  Extreme/can't do □

40. Concentrating on doing something for ten minutes.

None □  Mild □  Moderate □  Severe □  Extreme/can't do □

41. Walking a long distance such as half a mile.

None □  Mild □  Moderate □  Severe □  Extreme/can't do □

42. Washing your whole body.

None □  Mild □  Moderate □  Severe □  Extreme/can't do □

43. Getting dressed.

None □  Mild □  Moderate □  Severe □  Extreme/can't do □
44. Dealing with people you do not know.

None  [ ]  Mild  [ ]  Moderate  [ ]  Severe  [ ]  Extreme/ can’t do  [ ]

45. Maintaining a friendship.

None  [ ]  Mild  [ ]  Moderate  [ ]  Severe  [ ]  Extreme/ can’t do  [ ]

46. Your day to day work.

None  [ ]  Mild  [ ]  Moderate  [ ]  Severe  [ ]  Extreme/ can’t do  [ ]

Now to help me look for patterns in the answers may I ask you a few questions about yourself?

Age:

Gender:

Occupation:

Ethnic origin:
What is your disability (in your own words):

Thank you for your time in completing this questionnaire.

Any comments are welcome.
### Item-total Statistics

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### Reliability Coefficients

N of Cases = 100.0  
N of Items = 12  
Alpha = .8584
### RELIABILITY ANALYSIS - SCALE (ALPHA)

**Item-total Statistics**

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### Reliability Coefficients

**N of Cases = 100.0**

**Alpha = .8192**

### Reliability

***** Method 1 (space saver) will be used for this analysis *****
## Item-total Statistics

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## Reliability Coefficients

N of Cases = 100.0  
N of Items = 6  

Alpha = .8217

## Reliability

***** Method 1 (space saver) will be used for this analysis *****
## ELIABILITY ANALYSIS - SCALE (ALPHA)

### Scale Statistics

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### Liability Coefficients

- Number of Cases = 100.0
- Number of Items = 6
- \( \phi = .6197 \)

### Method 1 (space saver) will be used for this analysis

---

**Page 6**
**RELIABILITY ANALYSIS - SCALE (ALPHA)**

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**liability Coefficients**

of Cases = 100.0  
N of Items = 12  

pha = .8154
## Appendix E

**Table VI.** Correlation coefficients between self-silence and other sub-scales for men (n = 47).

<table>
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<tr>
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<th>Self-silencing</th>
<th>Identifying oneself as disabled</th>
<th>Identifying with group</th>
<th>Perception Others avoid discussing disability</th>
<th>Others' representations of disability</th>
<th>Level of impairment</th>
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**Table VII.** Correlation coefficients between self-silence and other sub-scales for women (n = 53).

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Table VII). Correlation coefficients between self-silence and other sub-scales for participants aged below 35 years (n = 22).

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<td>-.399</td>
<td>-.266</td>
<td>.183</td>
<td>.332</td>
<td>1</td>
</tr>
</tbody>
</table>

Table VIII). Correlation coefficients between self-silence and other sub-scales for participants aged 35 years to 50 (n = 25).

<table>
<thead>
<tr>
<th></th>
<th>Self-silencing</th>
<th>Identifying oneself as disabled</th>
<th>Identifying with group</th>
<th>Perception Others avoid discussing disability</th>
<th>Others' representations of disability</th>
<th>Level of impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-silencing</td>
<td>1</td>
<td>-.384</td>
<td>.111</td>
<td>.330</td>
<td>.311</td>
<td>-.205</td>
</tr>
<tr>
<td>Identifying oneself as disabled</td>
<td>-.384</td>
<td>1</td>
<td>.351</td>
<td>-.117</td>
<td>-.313</td>
<td>-.208</td>
</tr>
<tr>
<td>Identifying with group</td>
<td>.111</td>
<td>.351</td>
<td>1</td>
<td>-.126</td>
<td>-.265</td>
<td>-.293</td>
</tr>
<tr>
<td>Perception Others avoid discussing disability</td>
<td>.330</td>
<td>-.117</td>
<td>-.126</td>
<td>1</td>
<td>-.040</td>
<td>.264</td>
</tr>
<tr>
<td>Others' representations of disability</td>
<td>.311</td>
<td>-.313</td>
<td>-.265</td>
<td>-.040</td>
<td>1</td>
<td>.074</td>
</tr>
<tr>
<td>Level of impairment</td>
<td>-.205</td>
<td>-.208</td>
<td>-.293</td>
<td>.264</td>
<td>.074</td>
<td>1</td>
</tr>
</tbody>
</table>

Key. * = Correlation is significant at the 0.05 levels, ** = Correlation is significant at the 0.01 level
Table IX). Correlation coefficients between self-silence and other sub-scales for participants aged 50 years to 64 (n = 29).

<table>
<thead>
<tr>
<th></th>
<th>Self-silencing</th>
<th>Identifying oneself as disabled</th>
<th>Identifying with group</th>
<th>Perception Others avoid discussing disability</th>
<th>Others' representations of disability</th>
<th>Level of impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-silencing</td>
<td>1</td>
<td>.547**</td>
<td>.194</td>
<td>.584**</td>
<td>-.032</td>
<td>.246</td>
</tr>
<tr>
<td>Identifying oneself as disabled</td>
<td>.547**</td>
<td>1</td>
<td>.258</td>
<td>.324</td>
<td>.094</td>
<td>-.186</td>
</tr>
<tr>
<td>Identifying with group</td>
<td>.194</td>
<td>.258</td>
<td>1</td>
<td>.429*</td>
<td>.052</td>
<td>.027</td>
</tr>
<tr>
<td>Perception Others avoid discussing disability</td>
<td>.584**</td>
<td>.324</td>
<td>.429*</td>
<td>1</td>
<td>.314</td>
<td>.195</td>
</tr>
<tr>
<td>Others representations of disability</td>
<td>-.032</td>
<td>.094</td>
<td>.052</td>
<td>.314</td>
<td>1</td>
<td>-.140</td>
</tr>
<tr>
<td>Level of impairment</td>
<td>.246</td>
<td>-.186</td>
<td>.027</td>
<td>.195</td>
<td>-.140</td>
<td>1</td>
</tr>
</tbody>
</table>

Table X). Correlation coefficients between self-silence and other sub-scales for participants aged 65 and over (n = 24).

<table>
<thead>
<tr>
<th></th>
<th>Self-silencing</th>
<th>Identifying oneself as disabled</th>
<th>Identifying with group</th>
<th>Perception Others avoid discussing disability</th>
<th>Others' representations of disability</th>
<th>Level of impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-silencing</td>
<td>1</td>
<td>.146</td>
<td>-.025</td>
<td>-.232</td>
<td>-.332</td>
<td>.389</td>
</tr>
<tr>
<td>Identifying oneself as disabled</td>
<td>.146</td>
<td>1</td>
<td>-.029</td>
<td>.118</td>
<td>-.109</td>
<td>-.128</td>
</tr>
<tr>
<td>Identifying with group</td>
<td>-.025</td>
<td>-.029</td>
<td>1</td>
<td>.100</td>
<td>-.222</td>
<td>-.301</td>
</tr>
<tr>
<td>Perception Others avoid discussing disability</td>
<td>.232</td>
<td>.118</td>
<td>.100</td>
<td>1</td>
<td>-.057</td>
<td>.121</td>
</tr>
<tr>
<td>Others representations of disability</td>
<td>-.332</td>
<td>-.109</td>
<td>-.057</td>
<td>-.057</td>
<td>1</td>
<td>.137</td>
</tr>
<tr>
<td>Level of impairment</td>
<td>.389</td>
<td>-.128</td>
<td>.121</td>
<td>.121</td>
<td>.137</td>
<td>1</td>
</tr>
</tbody>
</table>

Key. * = Correlation is significant at the 0.05 levels, ** = Correlation is significant at the 0.01 level.
Table XI. Correlation coefficients between self-silence and other sub-scales for participants with mobility impairment (n = 29).

<table>
<thead>
<tr>
<th></th>
<th>Self-silencing</th>
<th>Identifying oneself as disabled</th>
<th>Identifying with group</th>
<th>Perception Others avoid discussing disability</th>
<th>Others' representations of disability</th>
<th>Level of impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-silencing</td>
<td>1</td>
<td>-0.118</td>
<td>0.149</td>
<td>0.325</td>
<td>-0.014</td>
<td>0.181</td>
</tr>
<tr>
<td>Identifying oneself as disabled</td>
<td>-0.118</td>
<td>1</td>
<td>0.003</td>
<td>-0.058</td>
<td>-0.567**</td>
<td>-0.112</td>
</tr>
<tr>
<td>Identifying with group</td>
<td>0.149</td>
<td>0.003</td>
<td>1</td>
<td>0.294</td>
<td>-0.339</td>
<td>-0.276</td>
</tr>
<tr>
<td>Perception Others avoid discussing disability</td>
<td>0.325</td>
<td>-0.058</td>
<td>0.294</td>
<td>1</td>
<td>-0.249</td>
<td>0.029</td>
</tr>
<tr>
<td>Others' representations of disability</td>
<td>-0.014</td>
<td>-0.567**</td>
<td>-0.359</td>
<td>0.249</td>
<td>1</td>
<td>0.161</td>
</tr>
<tr>
<td>Level of impairment</td>
<td>0.181</td>
<td>-0.112</td>
<td>-0.276</td>
<td>0.029</td>
<td>0.161</td>
<td>1</td>
</tr>
</tbody>
</table>

Table XII. Correlation coefficients between self-silence and other sub-scales for participants with sensory impairments (n = 29).

<table>
<thead>
<tr>
<th></th>
<th>Self-silencing</th>
<th>Identifying oneself as disabled</th>
<th>Identifying with group</th>
<th>Perception Others avoid discussing disability</th>
<th>Others' representations of disability</th>
<th>Level of impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-silencing</td>
<td>1</td>
<td>0.026</td>
<td>0.036</td>
<td>0.286</td>
<td>0.036</td>
<td>0.356</td>
</tr>
<tr>
<td>Identifying oneself as disabled</td>
<td>0.026</td>
<td>1</td>
<td>0.315</td>
<td>0.317</td>
<td>-0.040</td>
<td>-0.373*</td>
</tr>
<tr>
<td>Identifying with group</td>
<td>0.036</td>
<td>0.365</td>
<td>1</td>
<td>0.192</td>
<td>0.335</td>
<td>0.001</td>
</tr>
<tr>
<td>Perception Others avoid discussing disability</td>
<td>0.286</td>
<td>0.317</td>
<td>0.192</td>
<td>1</td>
<td>0.119</td>
<td>0.213</td>
</tr>
<tr>
<td>Others' representations of disability</td>
<td>0.036</td>
<td>-0.040</td>
<td>-0.335</td>
<td>0.119</td>
<td>1</td>
<td>-0.020</td>
</tr>
<tr>
<td>Level of impairment</td>
<td>0.356</td>
<td>-0.373**</td>
<td>0.001</td>
<td>0.213</td>
<td>-0.025</td>
<td>1</td>
</tr>
</tbody>
</table>

Key. * = Correlation is significant at the 0.05 levels, ** = Correlation is significant at the 0.01 level
Table XIII. Correlation coefficients between self-silence and other sub-scales for participants with degenerative disability (n = 23).

<table>
<thead>
<tr>
<th></th>
<th>Self-silencing</th>
<th>Identifying oneself as disabled</th>
<th>Identifying with group</th>
<th>Perception Others avoid discussing disability</th>
<th>Others' representations of disability</th>
<th>Level of impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-silencing</td>
<td>1</td>
<td>.573**</td>
<td>.571**</td>
<td>.329</td>
<td>-.139</td>
<td>-.254</td>
</tr>
<tr>
<td>Identifying oneself</td>
<td>.573**</td>
<td>1</td>
<td>.267</td>
<td>.268</td>
<td>.044</td>
<td>-.427*</td>
</tr>
<tr>
<td>as disabled</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifying with group</td>
<td>.571**</td>
<td>.267</td>
<td>1</td>
<td>-.004</td>
<td>-.123</td>
<td>.088</td>
</tr>
<tr>
<td>Perception Others</td>
<td>.329</td>
<td>.268</td>
<td>-.004</td>
<td>1</td>
<td>.137</td>
<td>.152</td>
</tr>
<tr>
<td>avoid discussing disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others representations of disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of impairment</td>
<td>-.139</td>
<td>.044</td>
<td>-.123</td>
<td>.137</td>
<td>1</td>
<td>.203</td>
</tr>
</tbody>
</table>

Table XIV. Correlation coefficients between self-silence and other sub-scales for participants with Chronic illness (n = 22).

<table>
<thead>
<tr>
<th></th>
<th>Self-silencing</th>
<th>Identifying oneself as disabled</th>
<th>Identifying with group</th>
<th>Perception Others avoid discussing disability</th>
<th>Others' representations of disability</th>
<th>Level of impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-silencing</td>
<td>1</td>
<td>.159</td>
<td>-.021</td>
<td>.492*</td>
<td>.170</td>
<td>.293</td>
</tr>
<tr>
<td>Identifying oneself</td>
<td>.159</td>
<td>1</td>
<td>.455*</td>
<td>-.150</td>
<td>-.250</td>
<td>-.307</td>
</tr>
<tr>
<td>as disabled</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifying with group</td>
<td>-.021</td>
<td>.455*</td>
<td>1</td>
<td>.097</td>
<td>-.238</td>
<td>-.369</td>
</tr>
<tr>
<td>Perception Others</td>
<td>.492*</td>
<td>-.150</td>
<td>.097</td>
<td>1</td>
<td>.092</td>
<td>.327</td>
</tr>
<tr>
<td>avoid discussing disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others representations of disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of impairment</td>
<td>.170</td>
<td>-.206</td>
<td>.238</td>
<td>.092</td>
<td>1</td>
<td>.061</td>
</tr>
</tbody>
</table>

Key: * = Correlation is significant at the 0.05 levels, ** = Correlation is significant at the 0.01 level
Notes for Contributors

Contributors should bear in mind that they are addressing an international audience. Manuscripts that do not conform to the requirements listed below will not be considered for publication or returned to their authors. Submissions will be seen anonymously by two referees.

Manuscripts, ideally between 3000 and 7000 words, should be sent to Professor Len Barton, Disability & Society, Department of Educational Studies, University of Sheffield, 388 Glossop Road, Sheffield S10 2JA, UK. Articles can be considered only if three complete copies of each manuscript are submitted. They should be typed on one side of the paper, double spaced, with ample margins, and bear the title of the contribution. The name(s) of the author(s), the address where the work was carried out and full postal address of the author who will check proofs and receive correspondence and offprints should also be included on a separate sheet. Each article should be accompanied by an abstract of 100-150 words also on a separate sheet, and a short note of biographical details. All pages should be numbered.

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Dear Mrs Supple

Exploring silence amongst disabled people (ACE/2002/109/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol (and the subsequent information supplied) and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed and that the following condition is met:-

- The Information Sheet for Participants includes a statement that all information will be handled in accordance with the Data Protection Act 1998.

For your information, and future reference, the Guidelines can be downloaded from the Committee’s website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2002/109/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

I should be grateful if you would confirm in writing your acceptance of the condition above, forwarding the amended document for the Committee’s records.

Date of approval by the Advisory Committee on Ethics: 19 February 2003
Date of expiry of approval by the Advisory Committee on Ethics: 18 February 2008
Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE
    Dr A Coyle, Supervisor, Dept of Psychology
    Dr M Finlay, Supervisor, Dept of Psychology