Systemic Therapy and the Social-Relational Model of Disability: Enabling practices with Adults with Intellectual Disability.

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Abstract
Therapy has been critiqued for personalizing the political (Kitzinger, 1993). The social-relational model (Thomas, 1999) is one theoretical resource for understanding the practices of therapy through a political lens. The social model(s) have viewed therapy with suspicion. This paper highlights – using composite case examples and the authors primary therapeutic modality, systemic therapy – some systemic practices with adults with Intellectual Disability (ID) that enact a position that it is suggested have some coherence with and, may reciprocally, inform the social-relational model. The practice examples illustrate a support system at risk of disabling those it is mandated to support, the possibility of therapeutically ‘successful’ practices (including systemic practices) and disablement going hand in hand; as well as the psycho-emotional (Thomas, 2006) consequences of the relational positions created by the service system. The paper concludes by suggesting that systemic conversations traversing culture, time and place can be a springboard to unearthing and challenging disabling ideas and practices.

Introduction
There appears at first, and possibly second, glance to exist a tension between the social model of disability and psychological therapy. The social model is the overarching conceptual framework of the discipline known as disability studies (Goodley & Lawthom, 2006). The model was originally predominantly associated with those with physical impairments although its implications for understanding the lives of people with ID are now an important part of scholarship in intellectual disability studies. (See for example, Nunkoosing, 2000; Clegg, 2006). The social model takes the view that social barriers disable those with an existing impairment. This is often contrasted with ‘individual tragedy’ and ‘medical’ models that are said to locate disability in the functional limitations of the person with impairment. Therapy has been critiqued as a normalising practice (Foucault, 1995), providing biographical solutions to structural inequalities (Bauman, 2003). The social model implies more than social disadvantage – a kind of cultural co-lateral damage – but rather a culture/society that actively makes life difficult for people. A disabling culture is depicted that undermines important relationships and the resources with which to build a positive sense of self. Disability results from ‘social oppression’, and hence a life characterised by domination, coercion, cruelty, tyranny, repression and subjugation (Thomas, 2004). One variant of the social model is Thomas’s (1999) suggestion of a social-relational model that

1 The use of the term psycho-emotional draws attention to the position that ‘psychology’ has often been an instrument of disablement.
also takes account of the social - relational processes that undermine the emotional and psychological wellbeing of disabled people. For the author of this paper the social – relational model is one response to the question of how to bring the social model of disability into the practice of psychotherapy. What is the social- relational model?

‘Disability is a form of social oppression involving the social imposition of restrictions of activity on people with impairments and the socially engendered undermining of their psycho-emotional wellbeing (Thomas, 1999, p.60)

I spend a part of my week in therapeutic practice in Community Learning Disability Teams with adults with ID and their networks. I practice as a systemic psychotherapist. Systemic Psychotherapy\(^2\) is a modality that creates the possibility for the therapist, the person and others significant in her or his life to come together and hear, create, elaborate and celebrate the stories that people bring (Haydon, 2008). Systemic therapy and practice has, over recent years, developed a useful place in the clinical psychology provision in community learning disability services (See for example: Fidel, 2000; Baum & Lynggaard, 2006; Baum, 2007, Clegg, 2006; Haydon, 2008). The notion of undermining social-relational contexts in addition to structural barriers has a richness that resonates with this approach to therapy as well as my experience of those with whom I meet in therapeutic practice. Many, often referred because they have been troublesome to others in the service system, have been provided with multifarious labels (challenging behaviour; autistic spectrum disorder; intermittent explosive disorder and so on) and bring stories of low self worth, feeling unattractive or wanting to harm their bodies. There are stories of feeling ‘stared’ at, of feeling rejected by a member of the service system, of loneliness and of being bullied on the street. What questions might emerge if we entertain a social-relational model? We might ask: what are the psycho-emotional consequences of

- Segregated schooling
- Assumed life-long unemployment
- Seemingly, endlessly repeating college courses
- Referral to a health care professional by a paid carer who finds you troublesome
- Being referred for a problem discoursed as located ‘inside’ of you

Once referred, most therapy, in most contexts, most of the time, is ‘individual’ and individualising. It invites an individual, focuses on individual adjustment, and employs ‘evidence based treatments’ for categories of diagnosable problems with change most often focused on an individual’s behaviour and

\(^2\) Systemic psychotherapy is also known variously as family therapy, systemic therapy & systemic family therapy.
cognitions. It is hardly surprising then if therapy might appear problematic for disability studies? Reeve (2004) pulls no punches:

‘Although the psycho-emotional dimensions of disability operate at an emotional level I would not suggest that this form of disabalism can be ‘fixed’ by a visit to a psychologist or counsellor; such professionals generally work within an individual model of disability and are more likely to add to rather than resolve issues associated with the psycho-emotional dimensions of disability’

p. 95

Does therapy always personalise the political? How do we practice in ways that take into account the critique of scholars such as Reeve? What might systemic therapy have to offer?

It does not require a systemic therapist to know that individual therapy or other individual ‘interventions’ are not an effective tool for many of the referrals received by a CLDT. Most teams will employ various forms of ‘ecological’ approach in addition to offering individual work. These approaches, such as Community Psychology (Kagan, Lawthom, Duckett & Burton, 2006), Positive Behaviour Supports (Carr, E.G., Dunlap, G., Homer, R.H., Koegel, R.L., Turnbull, A.P., Sailor, W., Anderson, J.L, Albin, R.W., Koegel, L.K. & Fox, L., 2002) and Systemic Therapy & Practice (Baum & Lyngaaard, 2006, Clegg, 2006) have much that separates them; however they are connected by an acknowledgement that a multi-level ‘systems’ perspective is most useful in this context. This is not hard to understand when one considers that people with ID rarely refer themselves, are very often discoursed as a problem for someone else, are usually the least powerful person in their relational system and are often unaware they have been referred to the team³. However, in my everyday practice I am discomforted by the idea that I may be contributing to disablement in my therapeutic work. Furthermore, a multi-level approach is not a sufficient condition for enabling practice. The large institutions were comprehensively ‘multi-level’ and ‘systemic’ in their practices…

**Systemic Approaches in practice.**

As a therapist, I have attempted to engage in systemic practices that might have congruence with the social-relational model of disability. The remainder of this paper consists of reflection on some of these practices.

‘Greg and Bob’: Assume the role of a cultural commentator...and offer this position to others

If we take seriously the idea that ideas in themselves can create disability then there are multiple sites where ideas may be powerfully disabling in the

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³ These elements of the referral system raise ethical questions for those choosing to work individually with the person referred.
lives of persons. One of these sites is the generational subjectivity or dominant culture of a time. We can offer to facilitate conversations that problematise these, often rather bullying, ideas.

In a meeting with a man with mild ID, referred for aggression towards his mother when she visited him at his group home, Greg told the therapist that he was angry that his mother had not treated him in a way that he would have liked. She had ‘hidden him away’, not spoken to him about his diagnosis, or told him why he had to go to a segregated rather than mainstream school. Greg brought his best friend from college to the meeting. When Greg spoke of his mothers hiding him away, Bob began to speak about Intellectual Disability. Bob told us that he knew that people were hidden away, kept in a hospital, and that people were ashamed of having a child with a disability. This had an interesting effect on the conversation. In addition to speaking about the issue in ‘personal’ terms, Greg, Bob and the therapist now began to talk about how ideas of Intellectual disability have changed over time and what ideas might have been around in Greg’s mother’s youth. More stories were told and Greg said that he had been worried and upset because how could his mother have done this and if she really loved him? In follow up conversations, where Greg usually chose to attend alone, we were able to open up a little space in the conversations to think differently about his mother and begin to see how, in the context of culture, his mother and himself had been disabled by historical ideas of disability and their associated institutions. Greg kept me informed of how his mother’s visits progressed and he found that he was less angry and eventually spoke with his mother about this during their time together.

Reflections
What was going on this example? Using a systemic theory known as the coordinated management of meaning (Pearce, 2008) to illustrate the process of the conversation we can see how we began by exploring briefly the episodes of anger and sadness; how these had contributed to a sense of being unloved and unworthy within the context of a relationship understood by Greg as rejecting and oppressive. Bob’s comments opened up the possibility of putting these in a cultural context in addition to (not instead of) the contexts of identity and relationship. This had the contextual effect, in subsequent conversations of reflexively influencing how Greg understood himself and his relationship with his mother. The ‘ordering’ of the stories changed and, in our conversations at least, we moved from the episodes with his mother and the understanding of self and relationship that was created for Greg as he made sense of them to conversations where culture became the highest context, (contributed the most meaning to other stories/levels) for making sense of relationship, self and episodes – or the lack of them. This ‘movement’ is shown below in figures 1 and 2.

Figure 1. Conversations before Bob’s comments on Culture.

Episode
Lack of conversations about ID
**Relationship**
Rejection, betrayal

**Identity**
Unloved, unworthy

### Figure 2. Conversations after Bob’s comments on culture.

**Culture**
Disabling ideas and institutions

**Relationship**
Managing disabling ideas in the context of a loving mother son relationship

**Identity**
Loved, experience of discrimination

**Episode**
More satisfactory Conversations about ID

This is of course the author’s narrative of the meetings. Greg and Bob may have had different stories to tell. The example suggests that people with ID can be positioned as a support to one another – they are often viewed by the service system as being troublesome to one another for example via the ‘challenging behaviour’ they may present. Disabling discourses can cross generations poisoning relationships and selves. Systemic conversations traversing culture over time (as well as place) can be a springboard to unearthing and challenging the disabling effects of these ideas.

**Janet, David, Zoe and Robert: Inviting others (who can help in overcoming disabling barriers) into the conversation**

Swain (2006) suggests that group work supports the politicisation of therapeutic practice. Although it has obvious potential for reducing disabling barriers there are limits to group work. A consciousness raised in a group consisting of labelled people, such as a self-advocacy group, may be of limited support to the person with ID who is living life in the midst of others (services, families, local community) that conceptualise a persons disability as synonymous with individual impairment and whose conjoint actions may be troublesome for the person and so groups may be augmented by involving those with whom the person shares their life. Systemic therapy and practice extends invitations to family members, friends, social care and health professionals, neighbours and so on and may create opportunities that would not have been possible with more truncated relational constellations.

Janet and David live together in an urban area with support going into their home. Janet works part time in a high street shop and David in a local garage. Following a referral from a social worker to a community

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*Due to considerations of both confidentiality and space, examples, although based on practices undertaken over a number of years, are composite sketches rather than descriptions of real people.*
learning disability team requesting ‘anger management’ for David, an initial telephone call from the team to Janet and David led to the agreement that a ‘one off’ network meeting would take place. After asking questions about who might be able to help, Janet and David decided they would like to invite a trusted friend and neighbour, Zoe, and the referring social worker, Robert.

At the meeting Robert (social worker) was interviewed by the therapist as the couple and their friend sat with the psychologist and listened to the interview. What were Robert’s concerns? Robert spoke of how he had been concerned with the anger that David had shown on the visits he made to the couples’ home. He was concerned about this and with Janet’s safety, living with someone who had difficulties with anger. He spoke of how much he felt they had progressed in their lives together and that he was concerned that this might be put at risk by ‘anger’ and wanted to find them some help.

Once the interview had continued for ten minutes or so, positions were exchanged and Robert sat with the therapist and listened in on a conversation between the psychologist and the couple.

Janet spoke of the anger shown by David and said that it seemed that it was at its worst when paid carers and other professionals came to the house. Janet had some good ways of managing it and helping David to relax again, including putting some of his favourite music on the stereo or asking if he might fetch something from the local shop (by which time he had calmed). She also spoke of her anger with some of the supporters that came to the house as she sometimes felt ignored by them. David spoke of feeling a burden that was too great for him to know how to manage. He told the meeting that support workers would speak to him about problems (they described them as ‘challenging behaviours’) they were experiencing in supporting his wife. He told the meeting that he would tell Janet about what the supporters had said and she would get upset with him and then he felt angry with her.

We had a group discussion and Zoe let us know how she was surprised by the concerns as she felt she knew them quite well and had not noticed any difficulties with ‘anger’. She spoke of how she had noticed another side to the couple’s life together and how they seemed to enjoy each others company. Zoe said she liked having Janet and David as neighbours and was interested in more conversations about she might be of help.

The social worker, reflecting on the conversation thus far, began to speak about how, although there had been little discussion of it, it was
clear to him now that he and others in the service system had come to relate to David as the more ‘able’ partner and had perhaps been expecting him to take the responsibility of a carer for Janet in ways he could not always manage. Robert also spoke of how he had been surprised to hear how much Janet helped David manage his emotions. Services, he felt, had become polarised and forgotten that David had needs, and Janet had abilities.

Towards the end of our meeting we asked how a useful change could be created in the relational system, by asking questions such as ‘Who might need to know about what?’ Janet and David decided that they would talk together with their support workers about the support they received and how it could be provided in a way that supported their relationship also. The couple also accepted an offer from Zoe to drop by to talk if there were difficulties or they wanted advice about anything. The issue of ‘anger’ was not a concern when a sixth month follow up call was made to the couple and to Robert.

**Reflections**

‘Janet David and Robert’ shows a support system at risk of disabling those it is mandated to support. Systemic practices such as couple work, as well as individual practices such as assertiveness training (for Janet) or anger management (for David) may have been ‘successful’ — and, simultaneously, disabling; compensatory rather than emancipatory. The couple or individual work may have neglected to address the social-relational barriers presented by the stories and practices of the service system as well as potential psycho-emotional consequences for the couple attempting to adjust to or ‘manage’ feelings of anger and frustration in their relationships.

The therapy took account of politics and power when it asked for the referrer to account for the referral in the presence of its subjects.5 Having Robert account for the referral in the presence of the Janet and David supported the couple to be offered a ‘right of reply’ that challenged the authority of the referral that located the problem both in David (aggressive) and, implicitly perhaps, Janet (vulnerable). The therapy took a step towards the emancipatory as it invited the service system to share response-ability in the creation of and solution to ‘problems’ it identified. Professionals have expertise. Response-ability is invited when the expertise and resources of professionals are brought to bear in the service of the persons referred. This occurred in the example with the bringing forth of the social workers abilities as he collaborated in the building of the new story. Disrupting the problematic binary opposition, carer/cared for was a central component in this example and questions that searched for Janet’s abilities offered the possibility of troubling the professional story, as characterised in the referral, of Janet as a

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5 Most individuals are referred to Community Learning Disability Teams by someone other than the person themselves.
victim with little or no agency. David was able to relate the psycho-emotional consequences (feelings of inadequacy and frustration with Janet) of the story that had developed in the professional system that he was the ‘carer’. As the lived aspects of this story began to overwhelm him his responses (anger and frustration) influenced the professional system to develop a companion story of David as aggressive and a risk to Janet as well as her carer. This positioning of David reflexively created great concern in the professional system. The inclusion of the couple’s friend, Zoe, added further possibilities for new stories and for the further development of community support.

Systemic therapists taking seriously the possibility of their actions having disabling consequences might consider actively avoid helping people with ID to ‘accept’ their disability and its psycho-emotional consequences. If disability and its psycho-emotional consequences are socially created, supporting people with ID to ‘accept’ disability as ‘theirs’ may constitute an act of oppression. What might have been the psycho-emotional consequences of focusing on supporting the couple to ‘manage’ feelings of anger and fear in their relationships? Therapeutic discourse is strewn with terms such as ‘managing’, ‘adjustment’ and ‘coping’ that imply these actions are central to a therapists practice.

This example suggests an ‘everyday’ utility of systemic therapy informed by the social-relational model of disability as it bids us to be wary of helping people with ID to adjust to a disabling environment whilst creating possibilities for new relations.

**Conclusions**

The Social Model and its variants – particularly the social-relational model – offer a political ‘edge’ to the work of systemic therapists and psychologists in CLDT’s. This lens sensitises the practitioner to structural and relational barriers. Systemic therapists and psychologists might well be tempted to describe this as ‘another lens’ with which to view a situation through; however this implies a relativity that fails to capture the importance of these ideas. The importance stems from the, very often, disenfranchised lives led by the people we are seeking to help. Social barriers can appear daunting, implacable and hence dispiriting to those who consider them. Why invite a space for them in the therapy room? There are, no doubt, limitations to what can be achieved in the therapy room; however, the therapeutic context can be a site for the unsettling and problematisation of disabling barriers. Barriers can be unearthered, scrutinised and collaborations of the resistant formed amongst those in relationship paid or otherwise. It is in these practices that systemic therapy reciprocally informs the social-relational model of disability. It does so with its offer of tools that support a productive and affirmative (Mclaughlin & Goodley, 2008) engagement in the social-relational worlds of those referred to therapy. Systemic therapy can enact an anti-disablement clinical practice. A theme of this paper has been the relational re-location of the problem and a re-contextualisation of the culture and service systems as producers as well as locators of problems – and disability - for referrals to the CLDT. This paper also raises questions that point toward further considerations. One such
question is the role of misunderstandings in the lives of people with ID\(^6\). At a certain point in time at least - the service systems understandings of ‘Janet’ and ‘David’ were partial, thin, and did not serve the couple well. It was a person with a label of ID (Bob) understanding of the history of ID that helped his friend ‘Greg’ with the creation of a new understanding of a central relationship in his life. Questions are raised concerning the experiences of the ‘socially mis-understood’ in the service system and beyond. What creates these misunderstandings? What might be the role of binaries such as social/individual, carer/carer for? This paper cannot answer these questions but suggests continued collaboration with those with ID and their systems of significant relationships in taking these, essentially ethical, questions seriously.

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References


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