

Acknowledging hidden emotions on Triangle Island

Triangle Island (*Figure 1*) is made up of three headlands joined by three beaches that together offer six viewpoints:

- **Service Rocks:** How the service is arranged
- **Person Head:** The whole-life experience and aspirations of individuals, including those who use the service
- **Community Point:** The nature of community
- **Empowerment Bay:** How the service can partner with the people it supports to promote empowerment
- **Engagement Sands:** How the service can take its place in the community it serves
- **Citizenship Coast:** How individuals and the communities in which they live cooperate to generate citizenship for all.

As Triangle Island is mountainous, it is not possible to climb to the centre and simultaneously take in all six viewpoints. Those who have lived

Abstract

This article extends the metaphor begun in *Living on Triangle Island* (Bates, 2010), which explored possible relationships between person-centred approaches, social inclusion and community engagement in the context of mental health. Here we examine some literature from the academic disciplines of disability studies and psychoanalytic therapy from the perspective of social inclusion.

Key points

- Insight from psychoanalytic approaches can help to understand how negative views about individuals and the community arise in services
- Unacknowledged, negative feelings towards people who use health and social care services can interfere with effective care delivery
- Similar processes may influence staff feelings about community groups and organisations, leading to unduly pessimistic beliefs about community representatives
- Discussing these processes using the Triangle Island metaphor may help staff progress

Key words

Disablism, institutionalisation, segregation, psychoanalytic

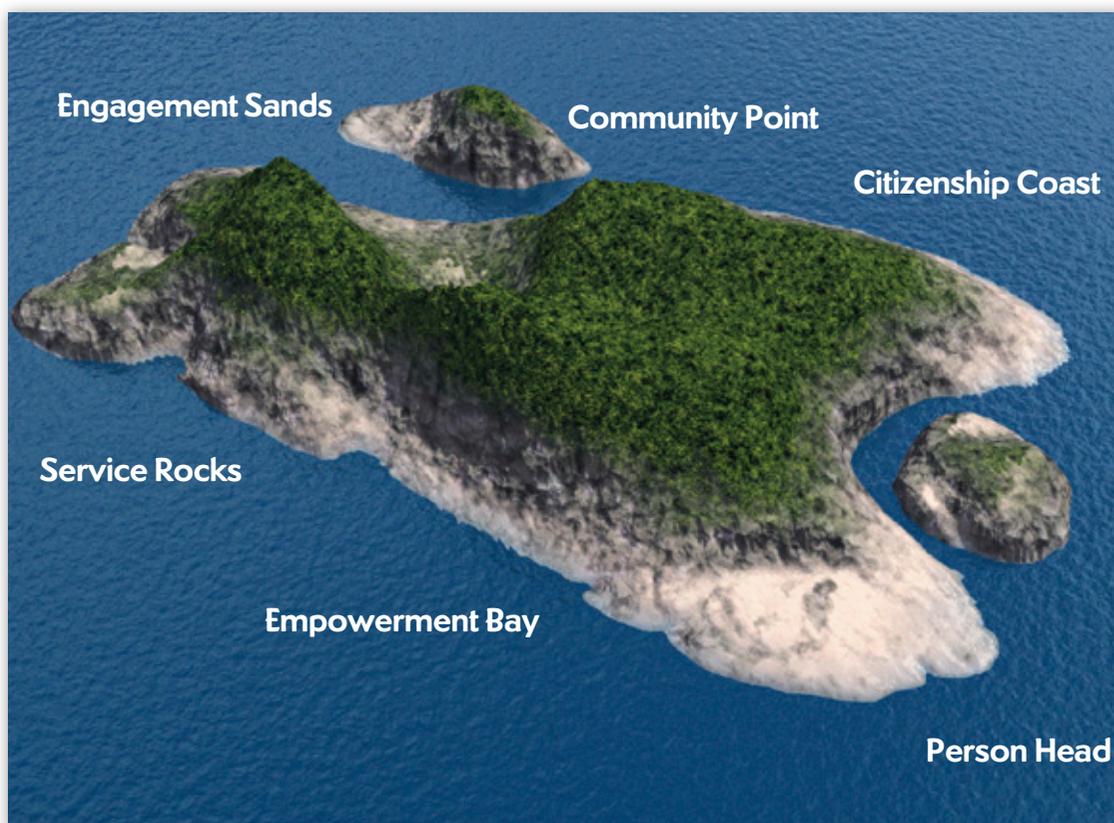


Figure 1. Triangle Island

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at one headland or one beach for a long time can travel to another place and try to understand what can be seen from this new viewpoint, but they can be no more than visitors and need to listen carefully to those who have lived all their lives in that place. Despite this, all headlands and beaches are set in relationship to all the other points on the island, and cannot each be understood in isolation. Changes made at one point of the island will affect all other points.

Sharks in the water

Just off the beaches around Triangle Island there are dangers. Disablism threatens citizenship, institutionalisation threatens empowerment and segregation threatens engagement. *Figure 2* illustrates this, and some aspects of these relationships will be discussed. There are several competing explanations of these dangers, of which the most notable is probably a Marxist economic argument that shows how the standardisation of the workforce at the beginning of the Industrial Revolution led to the exclusion of ‘unproductive’ disabled people and how workplace exclusion then spread to every facet of society. However, the remainder of this article explores an alternative psychoanalytic explanation.

These ideas are not, of course, mutually exclusive.

Disablism

The social model of disability separates the person’s impairment and the direct ‘impairment effects’ from the restrictions imposed by the physical and social organisation of the wider society. Society’s negative stereotypes are combined with the abuse of power to create disablism in a parallel process to racism or sexism. Michael Oliver, who named the social model, encourages disabled people to reject the ‘personal tragedy theory’ and instead politicise their struggle and campaign for the dismantling of discriminatory structures and the outlawing of excluding behaviours (Oliver, 1983).

Against this backcloth, a psychoanalytic approach to disablism has been contentious, as, at first sight, it relocates the problems of disablism back with the impaired person, rather than siting them in the structures and relationships of wider society. Indeed, some early social model theorists were so eager to keep the spotlight on the disabling community that they have been accused of neglecting the disabled person—the so-called ‘missing body’ in disability studies (Thomas, 2007). To explain this, Deborah Marks (1999) has shown

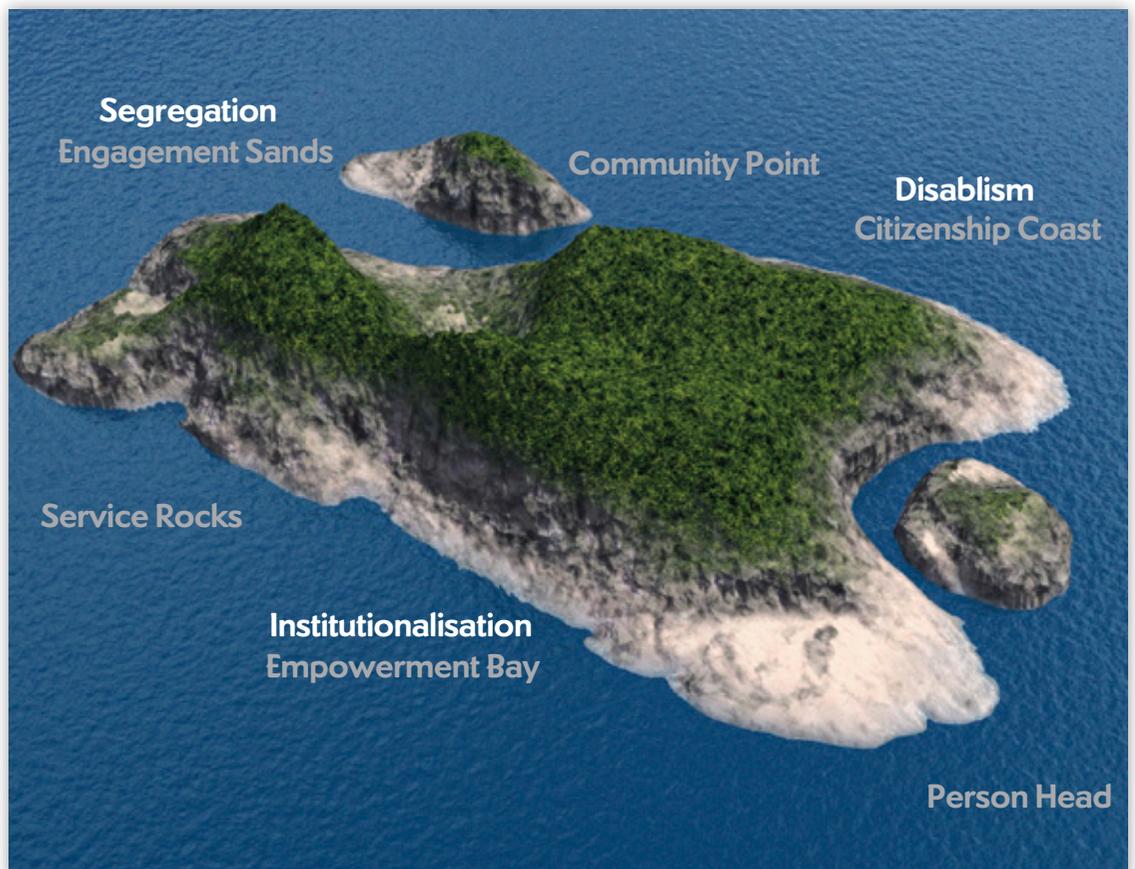


Figure 2: Dangers around Triangle Island

that when people from the 'non-disabled' public meet an impaired person, alongside other more pleasant emotions, they commonly experience anxiety as they are reminded of their own vulnerability and the fragility of their 'able-bodied' status.

In psychoanalytic theory, these awkward, anxious feelings are understood to be uncontainable and so are split from the more pleasant emotions and projected onto the impaired person. In this way, society denies its part in creating disability, and projects all responsibility on to the person (Sinason, 2002). As a result, the public's perception of the impaired person is marred with negative assumptions, as evidenced in many ways, ranging from the association of physical impairment with moral evil in films to casual interactions in which someone using a wheelchair is assumed to have impaired hearing and intellect.

This process has been established and reinforced for many generations, and has led not only to the consolidation of inequality in society, as seen for example in the unemployment statistics among disabled people, but also to the internalisation of these attitudes by disabled people.

Brian Watermeyer (2002) eloquently describes the experience of visually impaired people as simply 'not seen'. This is because the disabling society constructs buildings, issues communications, recruits workers and celebrates its culture as if everyone can see. When disabled people finally do get noticed, the real person usually remains hidden behind the label, and the public are so busy dealing with their own anxieties and vulnerabilities that they do not meet the impaired person as a whole individual at all. After a lifetime of this injustice, many disabled people internalise the devaluation and come to believe that they deserve no better.

By shining their collective torches on these emotional processes, Marks, Sinason and Watermeyer have helped us understand some of the forces that both create and sustain unequal and discriminatory practices. Only by acknowledging and dealing with the inner, emotional sharks of disablism that patrol the waters off Citizenship Coast will we have a chance of getting to the safety of the shore, of exchanging the injustice of disablism for the equality of shared citizenship.

Institutionalisation

Around 50 years ago Barton (1959) and Goffman (1961) explained how staff create institutional behaviours that reduce motivation and initiative among prisoners, military recruits and psychiatric

hospital patients. Taking people away from their families, removing opportunities for people to express their individuality (such as through choice of clothing or hairstyle), and dealing with people in groups rapidly strips away their sense of identity.

A psychoanalytic perspective examines the emotional processes that drive and sustain institutional behaviour, recognising that these psychological forces are likely to remain in play, even if the 19th Century asylum is closed. Staff, as members of the wider society, experience ambivalence towards disabled people, both respecting them and feeling a range of negative emotions. As before, the unconscious process of splitting can occur. Foster (2001) observes that this can lead to staff naively colluding with their clients by focusing on good aspects and ignoring their problems and destructiveness, or alternatively, to staff projecting the negative emotional valency on the disabled person, leaving the staff feeling virtuous.

This latter process perhaps goes some way towards explaining the embedded pessimism found in some psychiatric settings, where people sometimes report being told by staff that they will never work again after a serious mental health problem, will never be able to manage their own accommodation and will always need the guidance of professionals to help them live successfully. People who 'defy' the efforts of the health-care profession by self-harming or misusing alcohol or drugs sometimes report being subjected to abusive language and other mistreatment from health-care staff in a demonstration of the potency of these forces (Friedman et al, 2006).

Instead of sacrificing the uniqueness of the individual in the service of the standardised institution, the personalisation agenda invites the individual to design and commission his/her own support. As the individual is empowered to direct his/her journey towards recovery and employ his/her own support staff, so the damage of institutionalisation is abated and the institution itself disappears. The reluctance of some mental health staff to embrace the personalisation agenda may be a contemporary manifestation of damaging psychoanalytic processes, and point to the need to address conflicting and unconscious emotions.

Dealing with the sharks of institutionalisation that swim in the waters off Empowerment Bay will help mental health staff to be more effective in their efforts to support people to take control of their own lives.

Segregation

It is only in recent years that the UK mental health system has begun to deliberately explore its relationship with the community it serves. This has been fostered by the formation of foundation trusts within the NHS (2005), and government policy that requires local authorities to contribute to 'place shaping' (Department for Communities and Local Government, 2006). Some of the implications for the management and governance of mental health services were considered in the earlier article in this series (Bates, 2010).

We saw earlier that disability studies writers have examined the processes by which the community generates disablism (the 'sharks' that endanger Citizenship Coast), but we note that they have been almost silent about the positive side of community (Citizenship Coast itself) with little examination of community cohesion, social capital, diverse friendships and so on, or of the relationship between the negative and positive aspects. This may be the 'missing community' that parallels the 'missing body' referred to above. In other words, those who wish to enrich the traditional social model of disability by re-integrating the separated strands of mind/body, impairment/disability and individual/society into a comprehensive understanding, also need to plait together the separated strands of discrimination and acceptance in their view of community.

Across the island at Engagement Sands, there is little analysis of the relationship between services and their communities at all and very little indeed from a psychoanalytic perspective. An attempt is made to open this debate in the paragraphs below.

At the grassroots of mental health organisations, staff are required to build alliances with mainstream community agencies. For example, since the mental health service as a whole has a responsibility to improve employment outcomes for people who have used mental health services, frontline staff must speak with employers. In a similar way, frontline staff are increasingly required to engage with the whole gamut of mainstream community organisations, ranging from formal bureaucracies, such as universities, to ephemeral community networks and groups, such as friendship circles.

While many staff find these connections rewarding and hopeful, others may adopt an overly pessimistic and negative position. They persistently refer to discrimination from the community, re-tell stories of unfriendly employers and hate crime in neighbourhoods or offer up the hypothesis that

social capital is at an all time low. A psychoanalytic viewpoint may help to explain this.

Within the mental health service, staff occupy a familiar role, interact with others through a structured network of relationships, and interpret the world with the help of a host of cultural symbols such as language, uniform and norms of behaviour. Even minor changes—such as when a social worker's employment is transferred from the local council to the NHS without altering that person's place of work, colleagues or duties—can generate considerable anxiety.

Stepping beyond the health and social care world to make contact with employers, academia, sports, arts or faith-based organisations is to step into another world—another culture where language, relationships, symbols and values are all different (Bates and Rooms, 2008).

Such a move generates anxiety, as the person may be unable to understand this foreign land. He/she may become powerless, bewildered, stupefied by the unpredictable motivations, manners and jargon that form this unfamiliar culture. It is easier to treat the 'other' in a stereotypical way—to lump everyone together and assume they will all be the same. The mixture of positive curiosity and negative fear is hard to contain, so it is easier to split and project.

The mental health community is fantasised as wholly warm, friendly, and respectful towards people with mental health difficulties, while the wider community is demonised as harsh, unwelcoming and riddled with hate and abuse. Any evidence to the contrary (whether that is negative aspects of the service or positive aspects of the community) is quickly suppressed. After all, if we admitted that the community might include some who would gladly make adjustments to keep their employee or friend, then this would demand reciprocal acknowledgement that perhaps the mental health community is not uniformly warm and wonderful.

The dangers of this coastline of Triangle Island operate in a different way from elsewhere on the island. Elsewhere, the community has exercised considerable power over people with mental health issues for many generations to create and sustain disablism barriers. The service has similarly exercised considerable power over people with mental health issues to institutionalise and contain them. But what power does the service have over the community?

Although the service has power to ration access to psychiatric help to individuals and in its exercise

of community safety obligations, neither of these are sufficient to challenge and demand anything from the community as a whole. The power of the service over the community is insubstantial compared to the two other relationships that have been explored above. Moreover, the emotional driving force on this part of the island is simply the anxiety generated by the sense of unfamiliarity that mental health staff may feel when exposed to the commercial, retail or leisure sectors, compared with the anxiety that non-disabled people may feel when faced with people with impairments—the reminder of personal vulnerability, incompleteness and mortality.

While the psychodynamic processes at work between the service and the community are perhaps weaker than elsewhere on the island, they are nevertheless real. As they have little power to shape the community, the power is mostly diverted to fall on people who use the service. The staff who remain trapped in a fantasy in which the community is uniformly hateful segregate people with mental health issues away from such a hostile world and into the nurturing womb of the service.

Such staff will continue to find evidence that supports and justifies their internal process by gathering new stories of failed attempts at recovery and inclusion. Team managers, trainers and consultants who proffer inspirational stories, successful interventions and data about improving public attitudes will fail unless they simultaneously address these unacknowledged psychological processes.

Dealing with the sharks of segregation that endanger the waters off Engagement Sands is essential if the service is to make real progress in connecting with the community it serves.

Conclusion

This tour of Triangle Island invites us to begin again where we left off. Perhaps staff working in mental health services can deal with some of their anxieties, leave behind their fantasies and recognise the positive elements that exist in a mixed community that is constantly reinventing itself. The community is not just a series of ‘demanding publics’ (Goodley, 2010) but rather includes ‘appreciative publics’ within a vast array of individual and group responses, overlaid with and underpinned by multiple, fragmentary and contradictory cultural narratives. Through recognising this, the service can spearhead a new and more balanced relationship between itself and the community it serves.

In turn, acknowledging the fears that drive disablism may lead to a new relationship between the community as a whole and the individual members of it. This can help us abandon a simplistic and negative preoccupation with discrimination in favour of a richer view that neither denies the realities of injustice and oppression nor neglects the positive aspects of citizenship, social cohesion and celebration of diversity.

As people who use services exercise their citizenship and autonomy, this will help staff do the emotional work that is needed if they are to leave behind the negative emotions that drive and sustain disempowerment. And finally, through clearing these psychological barriers, staff will be able to embrace efforts to empower and personalise services. The overall results will be a richer community of vibrant citizens, supported by engaged and effective services. BJW

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