



Episode 4, Part 1: Cultural Humility in Special Populations
(Individuals with Disabilities)

Transcription

Jennie Min 0:09

Hello and welcome to an episode of Practicing Anti-Racism Clinically. Practicing ARC podcast is focused on combating systemic racism and elevating justice and inclusion in psychology through practical application of cultural humility and anti-racist practice in clinical settings. The podcast series will have episodes that are relevant for clinicians of varying training levels. So, from new graduate student clinicians to mid training graduate student clinicians to supervisors, our faculty and racial identities, for example, white or minority clinicians. In this episode, we will dive deeper into clinical practice with certain vulnerable populations. And for today, we are your host Jennie Min and Gina Erato. We are clinical psychology PhD students at Oklahoma State University.

Gina Erato 0:57

Today we are so fortunate to be joined by Dr. Watermeyer. Dr. Watermeyer trained as a clinical psychologist at the University of Cape Town, before completing a doctorate in psychology, focusing on disability studies, at Stellenbosch University. He was first editor of South Africa's first major text in disability studies, titled "Disability and Social Change: A South African Agenda," published in 2006. His second book, "Towards a Contextual Psychology of Disablism," was published internationally by Routledge in 2013. His most recent book is The Palgrave Handbook of Disability and Citizenship in the Global South, edited by B. Watermeyer, J. McKenzie and L. Swartz. Dr. Watermeyer has an extensive list of international journal publications, book chapters, and media appearances as a disability scholar and activist. He teaches on postgraduate programmes in disability and clinical psychology, as well as guest lecturing in medicine and rehabilitation science.

Dr. Watermeyer 2:06

It's a great pleasure to be here. Thank you for that lovely welcome.

Gina Erato 2:11

Thank you for being here.

Dr. Watermeyer 2:13

It's my pleasure.

Jennie Min 2:15

With Dr. Watermeyer, we will discuss working with clients with disabilities today.

Gina Erato 2:20

So, our very first question is where do we begin as therapists that work with clients with disabilities and how do we make that work in an inclusive way?

Dr. Watermeyer 2:34

Where do we begin? Well, the short answer is that we need to begin with ourselves. You know, for me, when we're working with any client population that has an identity different to ours, we need to begin by understanding our relationship with that identity and our relationship with difference in general as conditions.

When we talk about disability, I think it's particularly strongly the case. It's for the following reason. Disability is very evocative to us. It presses our buttons emotionally, because it tends to raise in us existential anxieties, which we all carry. Those anxieties are to do with things like our own bodily frailty, the reality that our bodies are changing, and that our bodies are impermanent; that we are all susceptible to illness. And injury introduces to us issues to do with that with our own mortality. And because of that, we find that around disability, we have this experience of being emotionally charged. There's an emotional valence around disability and often it involves anxiety. And there's no shame in this at all, you know, everyone has a degree of anxiety around disability. And what this tells us is that disability raises difficult existential issues in all of us. I mean, some have said that part of what makes disability difficult is that it reminds us of things we'd rather forget; it reminds us of the reality of the frailty of the body.

What that means is that when we are confronted with some of the disability, and it may be a client, What tends to happen is that our own vulnerabilities which we would rather disown or disavow or raised in us, and we are very prone to those times to protect to project those vulnerabilities onto our client. In other words, we find that we can quite easily sort of unthinkingly believe that we know something about our client's internal world, that we know something about herself. [We] think [we know] about how she feels about herself, something about how she moves through the world, what it feels like to be her, something about what it feels like for her to be in the room with us right now, even though we don't know her at all. Those feelings and imaginings have nothing to do with our client. They actually our own. And that had to do with our own relationship with disability because there are about our own anxieties and the anxieties that are raised by disability.

If we are to work with our clients with disabilities in a way, in which the room and the relationship between us is clear of projections, where we aren't imagining that we know what the patient's experience or the client experience is, but are able to really open our ears and our eyes to listening in a real way. And of course, that's the most important thing we can do as therapists. In order to do that, what we have to do is sort of clear away our projections through understanding our own relationship with disability. And that means confronting one's own fears and worries about the reality of what we all live with, as human beings. And that's the reality of the frailty of the body. It's something which, you know, rather than being something which divides us, disability and the reality that all of our bodies are frail and impermanent, that's actually something which we all have in common. It's something which brings us together. But we need to have confronted that and work with it in our own lives in order to get over the anxiety we have about relating to people with disabilities. That anxiety which tends to tell us that they are somehow intrinsically different to us. They're not, they are just human beings, like, you know, like you and I.

And I say, "Hi, I am a disabled person myself. And a person with disability. I mean, I use both terms." Once we have really worked with our anxieties about what disability brings, and then we're beginning to get to a point where the air is a bit clearer between us and the client with disability we are working with. We are more able to listen in a way which is not full of our own projections in imaginings but realizes that we are just sitting with another human being. A human being who lives in a particular situation, which is with a body that has functional limitation or impairment of some sort, but really just a human being, you know, like any of us who we can relate to, in that way.

I said it was a short answer, but that was quite a long answer. The important thing is that we begin with ourselves, that we begin with a real encounter with our own feelings about disability.

Because it's those feelings that we have about disability ourselves, which can sometimes get in the way of real defending and real relating with clients with disabilities.

Gina Erato 8:08

Yeah, so really describing this internal work that the clinician needs to embark on, really to kind of start assessing those physiological and psychological reactions to the idea of disability.

Dr. Watermeyer 8:27

Absolutely.

And what we discover is that, as in race, whether we are conscious of it or not, we've all undergone a racialized socialization, in a way through our early years and formative relationships. In an experience moving through the world, in our communities, we've all taken in a host of signals about what race means, about what it means to live in a different colored skin. We've taken those in because they're around us, all over the place. We've all sort of internalized the curriculum of meanings about what it means to be Black, what it means to be White. Along with that, you know, what it means to be to be Asian, what it means to be to be a woman, what it means to be a man. You know, we've taken in those ideas. And disability is no different.

As we come to disability as therapists, we need to look back and understand our socialization, what's been signaled to us about what disability means. We've all taken in messages from the world around us about what this disability means in an individual life, what it does to people. We've taken in ideas about what it feels like to be disabled, what it's like to be disabled. We've taken in ideas about what's good for disabled people, what they need, where they belong. These ideas are all, if you like, cultural accomplishments. They're all socially constructed ideas, which bring with them prejudiced and biased ideas about the lives of people with disabilities, just like we've internalized prejudices and biases in the case of race, or in the case of gender. In a very similar way, we need to look inside in a very humble and thoughtful way, we need to have conversations with one another, in which we bring out what our worries and fantasies and anxieties are about people who are different to us, in the sense of living with disability. We can bring those out onto the table. Think about where they come from.

Think about the experience we might have had as a seven-year-old child walking along the Main Street in our in our town, holding our mother's hand. When, across the road, there was perhaps another mother who had a son who had Down syndrome. And we were walking along and we saw this other child that looked a little bit different to us. We wanted to look and we were curious, and maybe your mother said, quite in quite a terse way. She said, "No, no, don't look," And she kind of pulled you aside and said, "No, don't look, you mustn't stare." And she sort of hurried up and quickened her pace to walk past the other mother and child.

What happened there is a powerful set of signals about what it means to have disability. What did you internalize? What did that seven-year-old boy internalize, or girl internalize at that time? Something to do with the idea of disability being something shameful. Something I'm curious about, but I shouldn't look at it. It's very different to us. Those people belong in places that are different to where we belong. We should stay away from them. These are all very powerful, and prejudice signals, just like the racialized signals, which we receive, as we do with people of different colors, through our formative childhood years.

So, we need to go back. And think about what those signals are that we received, and what they left us with in terms of our own anxiety ridden fantasies and imaginings about life of disability. So that we can unpack those, and understand them, and begin to let go of them. You know, we

haven't had opportunities to get over our anxieties about disability difference because the history of disability is, as I often put it, a history of apartheid on a global scale. Because the history of disability is one of segregation. Many or most of us have had very little opportunity through our formative years to live close to and get used to the lifestyles of people who have bodies that are different to us in terms of disability. And so it's not surprising then, that we are anxious about that kind of difference that we have worrying ideas and concerns about what it might be like to live with disability or to live close to someone who has disability. We haven't had a chance to, if you'd like, disconfirm our fantasies and our prejudices. So, there's no shame in that. But what it presents to us is the reality that we have work to do in order to get over those prejudices and fantasies and get to a point where we're not relating. When we're in the room with a client with disability, we're not relating to set up our own imaginings about that person's life. We're putting those imaginings aside, and just opening our ears and our eyes to another human being and giving her or him the opportunity to just tell us who they are and what life is like for them.

Jennie Min 14:13

Yeah, it seems like even before we step into a room with a client with disability, we need to process things ourselves and know what kind of beliefs we have, what kind of feelings we have about people with disability. So that doesn't get in the way of that therapeutic relationship with them that, so that we're able to listen, really listen to that person as a person.

Dr. Watermeyer 14:39

Jennie, you're right.

As I said, there's no, there's no shame in the fact that we have anxieties about disability. The reality is we've had very little opportunity to get over those anxieties. But as clinicians, it really is our responsibility to do that. When we are confronted with someone with disability, or what happens, I mean...

Imagine the situation where you say you're at a party and you walk into a room. And then, and you're standing with some people you know. And then into the room comes, say a wheelchair user, a man, let's say, for example, a man with quadriplegia. And [he] comes into the room. Let's just think about what might happen. And this isn't maybe analogous to what might happen in the consulting room. There is an anxiety that grows, and it's to do with difference. And it's to do with the fact that perhaps I haven't had an opportunity to engage with a man or woman who lives with quadriplegia before. And so, I'm not quite sure what to do with myself. The anxiety tells me that there's sort of a right set of things that I should do, but I'm not sure what they are. I find myself clutching around for the right thing to say, the right thing to do. Should I go down on my haunches to be at the same level as a wheelchair user? Or, or would that be patronizing? Do I look at him directly? Or would I then be at risk of staring? There's a sense of an awkwardness and something which I'm not quite sure how to deal with it.

All of this has to do with our anxieties about difference. And it's to do with the fact that, as I began by saying disability is exceptionally evocative to us. It presses our buttons and it raises those anxieties of 'what would it be like for me if I lost my ability for motor movement?' 'What would it be like for me if I lost one of my senses?' 'Now how would I feel if that were the case?' and it also raises for me the reality that, like everybody else, my body will slowly decay over time. That I too, will get old. That my senses will change. That my motor ability will change. That I will be confronted with the reality of my own mortality. All of these things are raised in a moment, as that that man with quadriplegia comes into the room.

And the danger is that all of my worries about myself. Because that's the important thing. These are not worries about him. These are worries about me. But the danger is that those worries about myself can kind of get in the way. Because in that moment, most of us, most of the time, we don't have the insight or the self-awareness to think well, 'oh, look, this man with quadriplegic with a severe physical disability comes into the room. And I see that it raises these anxieties that I have about what it would be like for me to be in those circumstance'. Our thoughts don't tend to go there. Instead, what tends to happen is that anxieties are raised for us about what it might be like to live with quadriplegia and then we project those imaginings onto the person in front of us. And we imagine, then, that we know something about his life, something about how he feels about himself, something about his sense of self-worth something about what it's like for him to be there at that party.

And you'll know, listening to this as conditions, that that when one is in a situation where one believes one knows things about one's client, which one hasn't been told, then surely you're in rather dangerous territory, because it means that listening has stopped. It means that you're not hearing, you're hearing something inside of yourself, not hearing what's being said to you.

Many people with disabilities describe having to live and relate to others in a way in which they have to spend a lot of energy, not so much just saying who they are to other people, but trying to disconfirm what other people assume about them. In other words, saying, "No, I'm not that. I'm not what do you think. It's not for me the way you imagined it is. I am not the person that you think I am. I don't live a life that you imagine that I do." When I say disability is evocative, what I mean is that it raises all these fantasies in us so quickly and so powerfully. And if we have strong beliefs about what life is like for other people, we're in danger, then, of silencing them and not giving them the opportunity to tell us what life is like for them. And that's why people come to therapy. People have something to say, want to tell us who they are, tell us what things are like for them, have someone who are able to listen and say, "See, it's like that for you, I get it. It's like that for you." In order to be able to do that, and really hear, one needs to have managed to clear away the clutter in the room. And with disability, there's a lot of emotional clutter, which begins with us.

Jennie Min 20:20

We have been talking about these misjudgments that people make with people with disabilities. So what are some common misjudgments that people can make when working with people with disabilities?

Dr. Watermeyer 20:34

Oh, there are many. Thinking in terms of the clinical setting, the first thing that comes to my mind is it's very common for non-disabled people to believe that the people with disabilities don't want to talk about disability at all, that somehow it would be a terrible thing. You know, that it's something we shouldn't raise, and there's a sense of a sort of elephant in the room, which shouldn't be spoken about.

And if we examine that assumption, just for a moment, we find that it really doesn't make a lot of sense, you know. Take me, for example, as someone who lives with severe visual impairment, and the idea that my visual disability is something which I wouldn't want to talk about or which I wouldn't want to feel like be reminded of really is, it's really quite absurd. It's something that I live with all the time. It's an absolutely integral part, not only of my lifestyle and my day, my way of working and doing things. It's also part of my identity. So, the idea that I wouldn't want to talk about it, that really doesn't make a lot of sense.

In fact, in my research, what most people with disabilities would say, is that what they dread the most, what they really don't want to pull, is to be related to by other people in an unreal way. Where there's a sense of treading lightly or walking on eggs. Where there's a sense, in other people, that there's something which can't be spoken about. So the relationship then becomes tense and awkward and a bit unreal. People with disabilities would much rather that you come out and say what your anxiety is what you're imagining, what you're feeling. Ask your questions about the disability. Don't be ashamed or shy about doing that. It's much better to be clear and humble and ready to be wrong.

And to maintain a relationship which feels unreal, we can't afford to do that as clinicians. What I would suggest to clinicians who are working with people with disabilities is it's very likely that you haven't had the opportunity to relate closely to someone with that disability before. I would sort of play open cards, as a clinician. I am working with someone, say, with a visual impairment, play open cards and say, "You know, I don't know anything or very much about visual impairment at all. This is quite new to me. So I understand now that I'm going to ask questions and some of them might be silly questions. And I'm sorry about that but I want to learn from you. I want the opportunity to sort of make mistakes so that you can teach me. You can show me what your experience is." Really bring it out into the open. So, we aren't both tiptoeing around the kind of political correctness. But instead, we're relating in a real way - two human beings. And when that happens, in a way, the disability, it always has importance because it impacts on people's lives that can make life very difficult for people with disabilities in ways I'll explain just now. But in another way, when one interacts in that real way, it can also sort of lose its relevance because what happens then is we are more or less, then, reduced to just two people. Two people in a room who are communicating with one another and trying to find out about one another's worlds. Well, in particular, you're finding out about the clients world because you're the therapist, but you see what I'm getting at. Just two people relating. I hope that answers your question.

Jennie Min 24:53

Yeah, that did. So, a lot of the times you may feel these anxieties [and] have all these beliefs. And then that would cause us to kind of tiptoe around or not ask because we're not sure. And then that, in and of itself, is not good, especially in a therapy setting. So it's important to be open, be okay, and vulnerable, and be okay with asking questions, and okay with being wrong.

Dr. Watermeyer 25:21

Yeah, yeah. I like what you said. Be okay with being vulnerable. You know, and to let yourself be open to learning. This is one thing we need to remember in all circumstances as clinicians. It is that we need to be able to learn from the client. And that means not have prior judgments, not have our own conclusions, our own assumptions, but constantly be open to the experience of being put right, by the client being told, in a slightly more refined and specific way than before exactly what the experience is like. So that we can through that build more and more accurate picture in our minds of what the client's internal world is like. And it's through that real empathy, real containment grow. And of course, that is therapeutically very important.

Gina Erato 26:28

Yeah, absolutely. I have been taking just so many notes on everything you're saying, Dr. Watermeyer. And specifically talking about hearing what's inside of yourself, when you are listening to your own socialization or pre-judgments, that listening to your client stops. And I just think that is such a powerful message to have conveyed. And we have another question on like socialization for you. What issues do we need to think about in relation to the socialization of people with congenital disabilities?

Dr. Watermeyer 27:08

In any situation of social inequality, where people of a particular identity are oppressed and marginalized in certain ways, the question of the extent to which those oppressive relationships are internalized by members of that of that oppressed group, that's always an important question. What do I mean by that is that oppression becomes internalized through socialization. And because it's not just a... Thinking about race, for example. It's inevitable that to some extent, members of oppressed racial minorities, or oppressed racial groups, through extended socialization in environments where devaluing ideas are passed around, about people of their identity, that some of those ideas creep in and become internalized. And that's where oppression really is at its most powerful. [It] is when those development ideas about oneself actually get inside of oneself. And this is not me saying this. I could refer to a whole clutch of writers from the black consciousness movement who would say the exactly the same thing. Coming from South Africa, I immediately think of Steve Biko, who talks about how if we are to overcome inequality, overcome relationships of social oppression, that members of the oppressed group need to look inside as well, and understand the ways in which they have internalized devaluing ideas about themselves. So, this is as relevant in the case of disability as in the case of other forms of identity and difference, and particularly perhaps in the case of congenital disability.

When we talk about congenital disability, we're talking about people who have lived with a particular kind of disability since early childhood or since birth. So, they have grown up surrounded by responses to their body, which is a different body, to the bodies of their peers. And what does that mean? You know, we are shaped powerfully... Our personality and our sense of ourselves, of who we are, is powerfully shaped by experiences of mirroring, which we get from the world around us. And that begins with the baby's experience of herself. Where did she see herself for the first time? She sees herself in a mother's face. And in the facial expression, which her mother directs towards her, tells her something about who she is. Because her mother is reflecting something back to her reflecting herself back at mirroring back to her the sense of who she is. Is she valuable? Is she precious? Is she beautiful? Is she important? So, what gets mirrored back, not just through the face of the mother in early life or the father, but mirrored back to us in all sorts of interactions in in all sorts of ways through the course of our lives, that shapes who we are, and shapes very much our sense of ourselves.

And in the case of disability, and people who grow up with bodies that are different, so some sort of visible disability. It might be a sensory impairment. It might be physical impairment. [It] might be an intellectual disability. It might be cerebral palsy. It might be down syndrome. Whatever the difference is. Children and young people grow up with a constant experience of having other people's response to them mirrored back from the world. Sadly and painfully, those mirroring experiences often carry meanings which are devaluing. They probably carry anxiety from parents who may be observing the child with a sense of worry and uncertainty about how to care for her and worry about her future or worry and a dismay about the fact that she's different to her peers, and a concern that you won't be able to feel okay about herself or manage her world.

So, what's happening there, right from the beginning, is potentially that the girl has an experience instead of her parents mirroring back something to do with pride and love. I mean, there probably is love. But there's also something else. [There] almost certainly is love but there's something else too. Something might be a sense that something is wrong with her. A sense, perhaps, that there might be some shame lurking there some way. There might be some anxiety about whether she'll cope. Where other children, perhaps, are getting messages of faith

from parents, the child with disability might be getting a sense, consciously or unconsciously, from her parents that her parents are really worried about whether she's able to cope. And if others are worried, particularly our formative relationships, are worried about whether we're able to cope, then, of course, we're going to worry ourselves now because everybody needs someone to have faith in them.

You know, that sense of self-assurance and confidence in our ability and in our creativity, it doesn't kind of spring from within in a magical way. We have to get that sense of confidence from somebody and these sorts of relationships, sorts of experiences in relationships around disability can be troubled in a way, which causes people with disabilities as they're growing up to internalize negative assumptions about their own potential about their identity. The sense of themselves somehow being damaged. They may have messages mirrored back to them which are distancing and which are rejecting. Perhaps that happens on the school playing field. Perhaps it happens in cultural events, recreational activities, religious communities and experiences of being rejected or being distanced, which leads to the internalization of a sense that one is of little value or less value. Internalization of a sense that perhaps one doesn't belong, and that there's something wrong with you, and that something is to do with your body and what's wrong with your body. And you can't participate the way that others do, because there's something wrong with you and that your place is sort of outside, not belonging with others. Sadly, our societies are absolutely saturated with these kinds of messages about disability and about people with disabilities. Of course, children and young people as they grow up with congenital disabilities. They internalize these messages.

So, a very important part of our role as clinicians is to really examine what's been taken in experiences of mirroring by the people with disabilities that we work with. What have they been told about who they are? What have they been shown about who they are about what their value is? About where they belong? What mistaken assumptions, what wrong prejudice ideas about themselves have they taken in? The more we can identify what those are and where they came from, the more our client will become conscious of them herself. Because until you become conscious of the sorts of assumptions about yourself, you don't see them at all, because they're a lens that you look through. They're all kind of assumed rather than something which one can identify. It's just the way things have always been.

It's our work as clinicians to make those invisible assumptions and unconscious ideas about the people with disabilities may have about themselves to bring them to consciousness, to point them out. To say, "Oh, but that's interesting that you feel that way about yourself. Where did that come from? Where did you first hear that message? What was it about that interaction that you had at Sunday school or the mosque or wherever it was, which left you feeling that way about yourself? What was the message that you took away? What did you believe that people felt about you and your worth?" These are all aspects of what I would call internalized oppression. And, if we are going to make real progress towards empowerment of people with disabilities, who, around the world, continue to often live profoundly marginal lives, and if we're going to make real progress towards empowerment, we need to bring these painful experiences and the meanings that are contained. Then we need to bring them out in the open to make them conscious, to help our clients grieve for the lost years, and the lost sense of self, and the pain of having taken in development ideas about themselves, in a way which allows for those ideas to be to be let go of, and to be replaced with the new experiences of mirroring, from you, the therapist, and from others towards building a new, more valued sense of self with disability is not a sign of damage. It's just an aspect of identity.

Thank you so much for sharing that.

And the connection between this socialization, especially for congenital disabilities, to our previous question where you said it seems absurd for people not to connect your disability to your identity. I feel like that was touched so much on this socialization answer. This is a part of an individual's identity. And it really would be almost remiss of the therapist to not make those connections and to be that sounding board to point out some of those questions, like you were saying, where could this have come from with internalized oppression?

Dr. Watermeyer 38:13
Absolutely.

And I want to sort of re-emphasize that in all of this work, you need to be led by your client. Because what you need to be doing is listening extremely carefully to what this person feels about herself. And these assumptions and feelings about oneself are often quite subtle and difficult to identify. And to really understand, it needs to be led by the client in finding out about her experience of her world, her experience of her own internal life, her experience of her relationships, and how she feels she fits into those relationships, what she feels is valuable about her, what she feels is wrong with her. What and where those ideas where they sprang from, in her socialization.

Part of what is hard about disability and what makes internalized oppression in disability, such a stubborn and difficult thing is the following. You know, when one talks about racism, for example, racism, also, of course, it can be very subtle. But generally, I would argue that when racism is happening, when somebody is behaving in a racist way, an oppressive way towards a member of a racial minority group. It's relatively easy to identify that racist behavior and that racist person as a bigot and someone who is doing something wrong, someone who is committing a social injustice, who is doing something oppressive and harmful. I mean, it can be subtle. But it can be made relatively clear, if you think who is doing the wrong thing in that interaction. Who is maintaining the relationship of inequality in a harmful way, in a bigoted way.

Now, the problem is that, with people with disabilities, oppressive behavior can very often come in the form of care. Because families that are very caring and have the best intentions and are full of love for a child or a young person with disability, may also at the same time, carry deeply limiting beliefs about the potential of people with disabilities and consequently of the potential of that young person in the family who lives with disability. They may have deeply prejudiced and limiting beliefs about what she is able to achieve, about how well she is able to feel about herself, about whether she's able to function in relationships, whether she's able to, to meet and find a partner and marry, perhaps, deeply limiting beliefs about her potential. You know, which don't come out of hatred or bigotry. They are cloaked, clothed in care and love, but nevertheless, are limiting and prejudiced ideas.

Now, it's far more difficult for that young person with disability to see clearly that the way that her loved ones are treating her carries with it a degree of oppression and of endless degree of diminishing of her. It's much harder for her to do that because they are her loved ones. She might be dependent on them for self-care, in terms of her activities of daily living and her daily routine. Maybe she needs assistance with activities of daily living. Maybe she needs assistance with a range of things with her work with her schoolwork. Whatever the case may be, it's very hard to meaningfully separate from people who you need physically and who are your close loved ones, and to recognize that some of the ways in which they treat you were actually harmful. That they harmed your sense of self. That they limited who it was you felt you could be.

That they caused you to internalize self-limiting assumptions about your potential. So, with disability, in a sense, it's that much harder to identify who the sort of villains of oppression are, if you'd like, who the real oppressors are. I know I'm speaking a little bit facetiously because, the question of who the real oppressors are is never a simple question. And if we think it is simple, then we're probably missing something. But with disability, it's that much more complicated. Because with disability, oppression and care are often deeply tangled up with one another.

Jennie Min 43:43

And that must not help with the internalization of these messages that people are getting because if it's obviously antagonistic versus it's wrapped in care and love... I feel like it's just going to be easier to internalize these messages that are coming to you.

Dr. Watermeyer 44:03

Absolutely, it's much more difficult to see them for what they are and to sort of take some of it and leave the rest behind. You know, say yes to some of it and no to the rest. And because these are messages which are wrapped in care. And we're also talking about, particularly with congenital disability and internalized oppression, relationships that have been that way for a person's entire life. So if you've never known anything different, all we have to work with, as we grow up and understand who we are and what our place in society is. All we have to go on, is what's mirrored back to us by those in our formative relationships and so it can be an enormous journey to travel, enormous amount of work to be done in order to really unpack and unpack those formative relationships and see the ways in which 'Yes, I was loved and I was cared for, but also I took in some ideas from my parents or from others who were teachers, from health professionals that were involved in my life. For much of my childhood, I took in ideas from those people about disability and myself, which caused me to believe that my potential was limited caused me to believe that I didn't have a right to be with other children, I didn't have a right to belong, I didn't have a right to participate fully in the activities of my community, and to see that I've internalized those things and to start beginning to say no to them.'

Jennie Min 45:34

So how might race ethnicity and gender identity intersect with disability that we need to think about as psychotherapists?

Dr. Watermeyer 45:43

Well, I mean, they do intersect with disability. And we know that the intersecting identities lead to experiences of inequality and disadvantage, which are sort of organismic interaction with one another way. Sometimes or quite often, the whole, in terms of a complex experience of disadvantage, is more than the sum of its parts. So, we do need to be thinking about that. We need to be considering how it was that different parts of our clients identity evoke different responses from the world as she was growing up.

Perhaps we're talking about a young person, a young woman, who is a member of an ethnic minority. [Let's] say she is an Asian American, who also has a disability. So, they are going to be cross cutting aspects of those three identities. So gender her ethnic identity and her disability, which are going to be evoking particular layers of responses in her experiences of mirroring from the world, which are going to be telling her, who she is, and what she's worth, and what our potential is, and where she belongs. And all those need to be thought about.

I mean, this may be controversial. But what I've learned over many years, is that I do believe that disability is a form of difference which has a particular profoundness about it, if you'd like, in the sense that, in a way, I believe that it surpasses other kinds of difference. And what do I

mean by that? I'm always surprised by how people with a range of different disabilities, even though those disabilities are very, very different. People with sensory impairments, people with physical impairments, people with intellectual disabilities. Very, very different, you know. Bodily differences, different lifestyles, emanating forms of impairment. I'm always amazed at how people have different disabilities quite readily moved to a place of identifying strongly with one another. Because there's something about being people who have experienced prejudice and discrimination on the basis of something to do with the body, which people identify in one another. And they identify that there's a similarity in those experiences. So it is through that the disability movement around the world has grown slowly but steadily over the course of the last, perhaps, four decades to a point where, for example, we are having this conversation right now, which we probably wouldn't have been having a decade ago. So, I think of disability as, as an extremely powerful and important aspect of difference in terms of identity. But of course, when we interact with others, and where we need to be thinking, as I say about the mirroring experiences, which emanate from a world which is gendered, a world which is "raced", and also a world which has a specific set of assumptions or prejudices about disability and how those things interact with one another. In creating a world of socialization which shapes the self of the client that you then find, you're working within your consulting.

Gina Erato 49:54

Yeah, so these intersections can be like unifying to the community, but also intensifying stressors just navigating the world that we live in.

Dr. Watermeyer 50:09

Absolutely, because in many parts of the world... I mean, I think specifically about South Africa, I know that this is true as well, perhaps to slightly lesser extent in the US, but economic inequality and racial inequality are, to some extent, superimposed. Certainly in South Africa and I know in the in the US as well. If one is Black, one is far more likely to be living in poverty. And if you combine that with disability, there's a powerful interaction that can happen there, because disability is expensive. And we know, for example, that families who have a child with disability are far more likely to be under economic stress, far more likely to be poor, and far more likely to not be able to escape from poverty than other families. What child with disability does is that it introduces a whole range of other expenses into the home. And they may be the expenses of transportation to rehabilitation stations, or transportation to a special school, which is far away. It may be to do with the fact that the child needs assistive devices or a special diet or special chronic medication. All of those things cost money, and maybe to do with the fact that the overall labor power of the household is diminished because one of the adults has to stay at home to look after a child who has severe disability and needs ongoing care. If you think about that situation where disability creates measurable impacts on the economic vulnerability of a family, overlay that with race and the fact that race and poverty are very often superimposed on mirror one another, and you will see clearly then that there's an increased sort of exponential vulnerability, which has to do with the fact that that race implies an economic disadvantage, which is then exacerbated by the presence of disability in families.

Gina Erato 52:33

So really hitting on this intersection and interactions between several different areas of life and stressors, for sure. So our final question, definitely shifting gears a little bit, but our podcast has been asking all of our guests this question, really to just create a spotlight for another psychologist. Who is someone in the field of psychology from a diverse or underrepresented a community that you think has done some amazing work, or deserves to be shared or recognized and just creating a spotlight on them?

Dr. Watermeyer 53:10

I'm sorry. Some psychologists specifically or someone in disability more broadly?

Jennie Min 53:17

I think it can be any scholar, any field as long as it's relevant.

Dr. Watermeyer 53:23

When I think about someone who's been extremely formative, in terms of my learning, and someone who is possibly the most influential right in disability studies in the world today, that would be Professor Tom Shakespeare, of the London School of Hygiene and Tropical Medicine. He is someone who lives with disability himself, Tom has. He's lived with Achondroplasia, which is sometimes called dwarfism. And he has just drawn the discipline of disability studies, which is a fully fledged discipline, which has been around since the 1970s. He's drawn it forward, just profoundly over the course of I would say, the last 15 years or so with an incredibly critical eye for recognizing where we need to be going in order to be braver about disability transformation. And one that includes thinking psychologically about what it is that it means psychologically and emotionally to live with disability in disablist societies, like the ones which we find in so many parts of the world. So, I would really sort of recommend his work. Professor Tom Shakespeare. I would really recommend it very strongly as someone who has the capacity to inspire us, certainly inspire me, to really think in a whole new way about disability, to really let go of assumptions, and to see assumptions for what they are, and to really move forward into a place where we see disability exclusion and disability inequality as a social problem that doesn't just confront people with disabilities that confronts us all. And really recognize the reality that if we create societies which are more accessible to people with disabilities, we create societies which are more just altogether and more caring for all of us. Because if we think about disability, if we think about disability access, what we are doing is thinking in a very careful way about how we can create societies in which people feel a sense of belonging in our societies, which are more usable, which are more welcoming to all of us, which are more caring to all of us. And his work really is highlighted and demonstrated that to me so that I would recommend his work very highly.

Jennie Min 56:05

That's amazing. So, we will include his profile and links to his work in our podcasts information.

Gina Erato 56:15

This was so perfect. And we are so grateful to have you as a guest, for you to share your thoughts with us. So, thank you so much. This was an amazing conversation.

Jennie Min 56:29

Yeah, and I think we've learned a lot as hosts of this podcast. And I think hopefully our listeners are learning a lot as well, because it's eye opening every episode that we do. And this episode for sure.

Dr. Watermeyer 56:46

I'm very glad to hear that. Thank you. It's been a pleasure.

Jennie Min 56:49

Yeah, so Dr. Watermeyer, some of our listeners may want to get in touch with you. So, could you please tell us where people can reach you?

Dr. Watermeyer 56:59

I can be reached on my email address. I'm always very happy to engage in the conversation. And that is that my address is Brian.Watermeyer@uct.ac.za.

Jennie Min 57:24

Perfect we will include your email address also in our podcast information so that our listeners can get in touch with you if they would like to. That's perfect. Great. Well, thank you so much. That is all for today.

Gina Erato 57:46

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