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Entering the world: dance movement psychotherapy and the complexity of beginnings with learning disabled clients

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This chapter explores the significance of beginnings in relation to working as a dance movement psychotherapist (DMP) with learning disabled clients. I explore the nature of ‘beginnings’ for the learning disabled infant, illustrating that experience with one mother’s story as she faces the news that her child has Down’s syndrome. I am not suggesting that subjective experience can validate generalisations about learning disability and I have no wish to reinforce a zeitgeist that seeks to theorize through personal experience rather than empirical research, mistaking ‘personal belief...for public knowledge’ (Anastasiou & Kauffman, 2011:369). In this chapter I explore how individual subjective experience of parents can bring into focus the uncomfortable and mixed feelings that confront us as we face learning disability as a lived reality. Through an analysis of that individual experience in relation to relevant literature, I identify issues that can help us to think about the implications for the transference when working as a DMP with learning disabled clients, in particular in relation to beginnings. I will finish with vignettes from my therapy practice to illustrate how the complex dynamics embedded in a client’s psychic infrastructure might manifest symbolically in the therapeutic relationship. I have full permission to share the stories in this chapter. Pseudonyms are used and some details have been changed to protect confidentiality.

A note on language

Throughout this chapter I use the term ‘learning disabled person’ (rather than people with a learning disability) to reflect discourses around discrimination and a ‘political expression of the fight for rights’ (Slorach, 2016:24) regarding disability. This use of language supports a social model of disability and locates the disabling factors in the social and cultural contextual

constructions (see for example Sinason, 1992; Slorach, 2016), rather than belonging to the person. The term ‘disabled people’ has been campaigned for and promoted by the disability movement (Slorach, 2016).

Beginnings

Beginnings, like endings, play a crucial role in therapy and our entry into this world is characterised by relational transactions that are non-verbal. Daniel Stern (2010) notes how ‘the primacy of movement and its dynamic features’ forms the basis of our ‘developmental infrastructure’ (:110). As a DMP I remain aware of the subtle nuances of beginnings as I meet with the particular developmental infrastructure of any particular client, the history of which becomes enacted in the intersubjective space from the moment he or she enters the orbit of my awareness. I pay close attention to my embodied felt-sense throughout the assessment and consultation process leading to the first encounter. I invest in my skills of observation and remain open to the way the client’s relationship with beginnings is characterised and evolves throughout the therapeutic process. Beginnings, like endings, hover continuously in the psychic space of the therapeutic process.

As a practitioner working with learning disabled people, I remain open to the inconvenient and uncomfortable truth of how many have experienced being welcomed into the world. These early relational experiences will shape the interpersonal dynamics at play and reflect wider socio-political perceptions. By listening to the dynamic processes emerging over time, I offer a therapeutic space for those complex experiences to be disentangled, felt, thought about, understood and perhaps replayed and reconfigured.

Learning disabled people have often experienced an atypical beginning. Sinason (1992) notes how ‘(w)hen the wished for baby does not appear it is hard for even the most loving,

resourceful parent to feel deeply attached.’ (:146-7). As illustrated in the following story, when a parent learns of his or her child’s diagnosis of learning disability, that ‘first mirror’ does not always reflect ‘beauty and joy’ (:147). Instead, the parental gaze is tinged with disappointment and grief.

The story that follows is one mother’s account of her daughter’s birth. The mother-to-be is on trip to a botanical garden when she goes into labour. A small girl skipping by comes to represent the mother’s idealised notion of the anticipated child. After the shock of an emergency caesarean, there is a sense that something isn’t right. The parents are avoided by nursing staff who await the paediatrician’s return after the bank holiday weekend. The parents begin to bond with the baby before they are confronted by the news that she is learning disabled. The news is delivered by a paediatrician who seems ill-equipped to hold the emotional impact of the news. A junior doctor is able to sit by the parents when their world is turned upside down by the shocking news. The baby is an unexpected guest and the parents too find themselves on the threshold of an unexpected and unknown world.

In the humid Palm House at Kew Gardens, a pregnant woman descended the spiral staircase. Her stomach tightened and she clutched the iron hand rail to pause. The contraction passed and she continued to spiral down, sensing the tailback of August bank holiday visitors stretching behind like a giant tendril.

She became absorbed in the sensorial world of the Palm House. Metal hoses hissed like giant anacondas and steaming droplets of water cascaded onto the leaves of banana trees and cocoa plants in the simulated, tropical atmosphere. A bulging droplet fell from a leaf as if in slow motion. The leaf rebounded with a shudder. She felt the shudder echo in her spine and put her hands protectively on her stomach, feeling the baby beneath the tightly stretched skin. A small

child in a floral dress skipped by, calling to her father. The woman smiled, remembering her visits to Kew as a child. As she did so, she gazed into the crystal ball of her baby's future; a carefree child, skipping into adulthood and sailing into the next generation. It was an uncomplicated vision.

Exotic scents hung in the hot air that brushed against her skin as sounds intensified in volume. The anaconda hissed at intervals from above. Conversation slithered in and out of earshot.... '...look daddy...', '..did you see the....', Her eyes followed the little girl with tousled ringlets, skipping back and forth as her parents wandered around the palm house. Her stomach tightened again.

Her partner turned to her.

'I think we should go.' she said.

In the maternity ward they put her on a monitor. She saw the panic on the faces of the nurses. 'The heart's dipping.' she heard. 'Sign this form.' She held the pen over the paper and watched it scribble illegibly. The anaesthetist peered at her over his green face-mask and the world went black. Her husband waited anxiously in an adjacent room. The baby was lifted into the world and wrapped in a blanket. As the woman came to, her partner greeted her, holding in his arms the tiny being with silky blonde hair.

That night the woman lay awake on her back, unable to shift position due to the caesarean.

Her arm was tucked around a small bundle of white blankets.

'Just hold her for a moment and I'll be back to put her in the nursery...' said the nurse, '..she's rather small and getting cold.'

The nurse threw the woman a fleeting glance and raced out of the room. She didn't return.

The woman peered at the tiny baby, overwhelmed by the delicate softness and the delicious smell of new-born skin. The exquisite features and the thick mop of blonde hair held an unfamiliar wonder to the woman, who'd never seen anything quite so beautiful. The curtains were open and a full moon hung in a clear velvet-blue sky. She stroked the fine hair on the baby's skin with the back of her hand.

Her husband phoned around with the news. Hearts warmed. Glasses were raised in celebration. Knitting needles crafted pink matinee jackets. Congratulations filled carefully chosen cards. The news echoed through the trees. The anaconda hissed a warning into the air, which hung suspended, waiting to fall from the edge of a leaf. Mother and baby drifted into a blissful sleep.

'Don't tell me you've had this baby in your bed all night!' a nurse scolded, not long arrived on her Sunday morning shift.

The woman woke with a start. The bright sun shone through the window, making her blink. The baby was whisked into the nursery with talk of a bottle to top her up.

'please don't give her a bottle' said the woman.

The nurse ignored her, 'you get some rest now...we'll bring the baby back later.'

The woman didn't want to rest, she wanted her baby back. She had a strange sense of being avoided by staff. They raced in and out of her room, avoiding eye contact. Her husband arrived.

'.....the baby is in the nursery; can you get her back' said the woman.

After a while, her partner wheeled the baby back into the room. The nurses had said they needed to consult the paediatrician. It was a bank holiday weekend and medical staff were mostly away. The baby was small and slightly blue, they'd said.

Visitors came with cards, flowers and presents. A helium balloon on pink ribbon wavered in the heat that shimmered from the hospital radiators.

The bank holiday weekend was over. The paediatrician entered the room with a junior doctor and some anxious looking nurses.

'Well, how are we all?' said the paediatrician brightly.

The room was lined with professionals, looking anywhere but in the woman's eyes. The woman had made her way tentatively from the bed to a chair.

'May I take the baby?' asked the paediatrician, lifting the baby from the mother's arms. She held the baby at arm's length before placing her on her tweed lap. Unwrapping the blanket, she allowed the baby's arms to flop down either side of her knees. The paediatrician's natural-tan tights had a sheen, which caught the sun, causing a shaft of light to curve over her knee and follow the contour of her athletic calf muscle down to her black-patent court shoes.

'Have you noticed anything about your baby?' she asked, slowly shifting her attention from baby to mother.

The woman felt her chest tighten and her spine straighten. She shifted her glance from the paediatrician's professional smile to the baby. As she did so, the paediatrician began to bounce the baby's arms in her hands.

'..can you see she's a bit floppy?'

The woman wanted the earth to stop turning. She wanted to be back in bed with her arm round the baby, as the full moon shone through the window. The paediatrician put her fingers in the baby's palms. The baby didn't respond, but instead, moved her head to gaze towards the line of nurses; each standing upright, as straight-backed as Mary Poppins.

'...andit would be usual for the baby to grip...?' she went on. The woman continued to stare, her blue eyes piercing the paediatrician's charm, defying the theft of her dream.

'....and have you noticed the shape of her eyes?' the paediatrician went on, '...the epicanthic folds, which are typical of a certain syndrome. Do you see what I'm getting at?' She drew her finger-tips slowly together to indicate a thin, elliptical shape. The paediatrician was becoming unnerved by the woman's expressionless stare, which gave nothing away. The woman sat silent in her chair. The paediatrician held her precious baby on her lap like a faulty specimen.

'...the baby obviously has Down's Syndrome' the paediatrician paused. '...you hadn't noticed? and I suspect there's a problem with her heart, as she is blue around the mouth. It's not uncommon.....there can be little doubt, but obviously we'll do tests.....um.....straight to the special care baby unit I think' said the paediatrician, over the woman's head.....'we'll get her to Great Ormond Street a.s.a.p.....oh, and can someone get mum and dad a cup of tea?'

With that she smiled with a sympathetic tilt of the head, put the baby in the plastic hospital cot and swept out of the room. The anaconda hissed a billion pieces of shattered glass into the hospital air. The professionals clicked their heels and stepped up their choreographed routine, reflecting back the paediatrician's reassuring, professional smile. A nurse pushed the baby out and was followed by a procession of professionals, who jostled for a hasty exit.

Suddenly the room was empty, except for the woman and her husband. They stood staring at the open door. A shiny blue hospital floor led down an empty, silent corridor. They stood in a deathly silence. The paediatrician's words echoed in the woman's mind '...hadn't you noticed?'why hadn't she noticed? They stared at each other in disbelief. Tears welled up in their eyes and in their confusion they quickly averted their gaze from each other. The flowers spilled out of the hospital vase and the helium balloon blushed a deeper shade of pink. A baby began to cry from an adjacent room. The sound was unbearable and cut through the air, shattering any small illusions that remained. The beautiful baby with the soft skin and the

shock of blonde hair, who'd slumbered in her arms by the light of the full moon, hurtled out of sight, into oblivion. The young girl with the tousled hair, stopped skipping back and forth and turned to stone. Warmed hearts turned to ice. Celebratory glasses slid inconspicuously back into the cupboard. The scribbled words of congratulations turned to mournful lamentations. The knitting needles stopped in their tracks and the half finished pink matinee jacket was put to one side in remembrance of what might have been. The room became a deep pit of grief and despair. There was no cup of tea for mum and dad.

The woman headed slowly for the door and her partner followed her into the lift. As the doors opened at the bottom they came face to face with their first visitors of the day. The woman's face was ashen. She looked at her friend, whose beaming smile crumpled, as the woman lifted her shoulders in despair '...speak later?' she managed to say. Her friend kissed her on the cheek, whispering 'God Bless' into her ear.

At the special care baby unit, the parents were given green gowns and were instructed to wash their hands. The room was even hotter than the ward. Her baby lay in a transparent incubator and had a white knitted hat on her head. There was a tube in her nose, strapped to her face with plaster and she was wired up to a heart monitor. She lay on her back, with her head tilted to one side.

'The paediatrician would like to see you when you're ready' said a nurse with a kindly smile. They hovered at the office door. The paediatrician hadn't seen them coming and was on the telephone. She looked up

'oh, sorry to keep you waiting, do come in.' she said brightly.

'To be honest', she said 'you need to think very carefully about what you do. It's quite OK to leave the baby with us and there are always foster carers who can take on these sorts of children. You're both young. It might be best just to go home and start again. It looks like

there's a serious heart problem as well, so I imagine the chances of survival aren't great.

There's another one in the corner over there. He's not so poorly, but the parents already have one child and have decided that he would be too much.

Feeling stunned, the couple went back to the baby and sat either side of the incubator. The junior doctor, who had accompanied the paediatrician when the news was delivered, approached them. She pulled up a chair and sat close by. She said nothing for a while. After a couple of minutes she said quietly 'I don't think you got that cup of tea you were promised. Sorry about that.' The couple looked at her. The dad shook his head 'not to worry' he said and they all looked back at the baby. Some more minutes passed and the doctor said 'It's a lot to take in.' She continued to sit with them, gently suggesting that she could offer further information when they felt ready to hear it.

The journey had begun. The small baby lying in the incubator had entered the world.

The loss of the imagined child

The initial shock at the loss of the imagined child sends a parent into a process of grieving in coming to terms with a child's learning disability, as a medical diagnosis and as an immediate lived experience (Al-Yagon, 2015; Barr & Millar, 2003; Harnett & Tierney 2009; Kenyon, 2013; Leff-Taner & Hilburn Walizer, 1992; Rolfe, 2013; Sinason, 2002; Strecker et al., 2014).

When a parent becomes aware of his or her child's disability, he or she needs to adjust from the idealised child constructed in his or her mind's eye.

The process of grieving this lost imagined child is complex and the parental adjustment is a non-linear process (Rolfe, 2013). Barr and Millar (2003:189) cite 'shock, confusion, anger or disbelief' as common responses to the initial diagnosis. This response to the news begins a

process of adjustment which can continue to be brought to the surface, for example, in milestones such as going to school, reaching puberty and entering adulthood. The capacity of the parents to manage that adjustment varies enormously (Neely-Barnes & Dia, 2008). It is interesting to note that in a recent empirical enquiry into the emotional and coping resources of parents of learning disabled children, the attachment patterns were found to be more influenced by the parents' own developmental histories, than by the stress of parenting a learning disabled child alone (Al-Yagon, 2015). The wider picture of the impact of the diagnosis on parent and child has many variables that reflect the particular circumstances of each respective family. However, caring for a learning disabled child brings with it increased challenges to the family environment, which has enormous potential to lead to increased levels of stress and health issues (Heiman, 2002).

Feelings of shame can lie beneath the experience of being a disappointment to the world as the idealised child is lost. For the learning disabled person, the world can be a confusing, hostile and unaccommodating environment. Research exploring the direct experience of learning disabled people, demonstrates that low self-esteem is a common feature of that experience along with feelings of shame and of being stigmatised (Dyson 1996; Jahoda & Markova, 2004; Kenyon et al., 2013). Profound and multiply disabled folk can become 'defined by their most prominent 'deficits' rather than being seen as complex beings...' (Sheehy & Nind, 2005:35). As oppressed and marginalised members of society, learning disabled people can be vulnerable to mental health problems (:2005). However, research into 'Things that Make People with a Learning Disability Happy and Satisfied with Their Lives' (Haigh, et al., 2013:26) concludes that when they have access to the necessary provision and are supported to make decisions, learning disabled people can feel happy and satisfied with their lives. This right to participation is supported by the key principles of the Mental Capacity Act, which underpins

good practice in supporting learning disabled people to make significant decisions in their lives (Ramasubramanian, 2011) within an enabling context.

A particular subjectivity

As with labels attributed to any category of peoples, the notion of learning disability brings with it culturally specific definitions (Neely-Barnes & Dia, 2008) and constructed beliefs, that carry barriers, oppressions, potentials and opportunities. The definition ‘learning disability’ describes a person only by his or her diminished capacity for cognitive thought. The body is absent from this definition and the individual is identified by what he or she is not. In her book ‘Unimaginable Bodies’ Hickey-Moody (2009), notes that diagnoses such as Down’s Syndrome, generally arise from medical discourses, which have evolved in the quest to repair and resolve. These discourses are based on an idea about how bodies and minds *should* function and serve as tools for fixing, rather than tools for thinking (Hicky-Moody, 2009). Such discourses carry powerful potential to suggest that particular physical features denote ‘a specific kind of subjectivity’ (:13). Social identity and individual subjectivity becomes bound to medical knowledge and these medical discourses shape the world, rather than conceptualise human diversity. The imagined normal body holds enormous power, and this notion is embedded both in the cultural psyche and in the individual stories of learning disabled people and their families. As practitioners working with the body, it is crucial that we remain connected to our own relationship with embodied otherness, both comfortable and uncomfortable, familiar and unfamiliar, in order to build a mutually understood embodied language as central to the therapeutic relationship. Understanding the subjectivity of learning disabled people may lie primarily in our capacity for non-verbal ways of listening, experiencing and attuning through an embodied sensitivity.

Embodied awareness

The intricacies of the moving body are primary to the human experience. Stern (2010) notes how the foetus in utero becomes increasingly responsive through movement as he or she develops a ‘felt aliveness’ (:104). In the therapeutic process, the intersubjective language of the body can serve as an immediate source of communication and this emergent ‘felt aliveness’ (:104) becomes a place where therapist and client can begin to converse and to listen and respond through the senses.

Our embodied awareness is particularly crucial with clients who may have limited speech (Corbett, 2009; Sinason, 2002). The ability to attune on an embodied level and to mirror the affective essence of the client’s story opens opportunities for the therapist to experience and understand the transference and for the client to feel heard, seen and understood. Bridges can thus be built between the client and the immediate environment, between the therapeutic space and the outside world and between past experience and the current reality of the therapeutic relationship.

Corbett (2009), a psychotherapist, writes about the intensification of his own embodiment when working with a learning disabled client. He needed to remember his own aliveness with a brisk walk in order to ‘remain fully alive in the face of severe deprivation, abuse or mindlessness’ (:58). Corbett notes the ‘overwhelming tide of primitive emotions’ (:59) that can characterise some of our work with learning disabled clients. The implications of these dynamics can be echoed in the disability transference in therapeutic work with learning disabled clients, when the therapist can find herself ‘working with lack, absence, and the birth of the baby who is longed for and not longed for’ (:55). Movement is ideally placed as a modality in this work due the primacy of movement as ‘our most primitive and fundamental experience’ (Stern, 2010:19)

Working in the transference

Working in the transference is central to psychodynamic psychotherapy, as the therapist attends to the live, dynamic interplay of unconscious processes that arise in the immediate relationship. Internalised models of significant relational figures shape the dynamics of that relationship. The specificity of learning disability, as a lived experience, offers layers of complexity in this relational process. In the ‘disability transference’ (Corbett, 2009:49) the therapist can find that she or he needs to provide an anchor that grounds the learning disabled client in a sense of his or her own embodied presence. Corbett (2009) suggests that as therapists, we need to be prepared to hold the difficult feelings of ‘...hopelessness, dread, deadness and fear’ (:57) that are potentially overwhelming for, and disavowed by, the client. One of our tasks as therapists is to bring these feelings to consciousness so that they can be experienced, felt and thought about, rather than defended against and acted out.

I remember working with Julie, who seemed only able to discover her felt aliveness in front of the mirror attached to the wall in our therapy space. It was as if Julie’s ‘dynamic forms of vitality’ (Stern, 2016:7) had been muted. Julie had been born into an atmosphere of loss. A teenage sibling had died just before her birth and at the same time, the father had left the family home. The already grieving mother was then confronted with the label of learning disability when her baby was a few months old. Relationship was risky for Julie who took comfort in her own reflection, unable to trust that another would be able to welcome her into a connection and to hold her range of intense feelings. I processed the strong counter-transference feelings of being unwelcome, useless and excluded. In defence of those feelings, I found myself becoming bored and extremely tired during sessions. Something in the embodied connectivity seemed dead. I found a way to make myself physically and psychologically present by bringing my awareness to my muscles, bones and joints in order to foster my own capacity to enter the session in a state of embodied awareness. I managed to open my awareness to Julie’s

unbearable projections, so that I could tolerate and contain them. As I became more conscious of how I was being impacted on a somatic level, I became better able to provide a welcoming space for Julie. A fleeting glance seemed to be the beginning of a process of building a connection which developed through a sigh, a shrug and a shared wriggle. I learned to experience whatever emerged as not only as *enough*, but also as intriguing. I was able to begin to disentangle the complex interpersonal fantasies and to facilitate a shared reality between us.

It is crucial, then, that the therapist has explored his or her own unconscious relationship with the notion of disability, in order that unprocessed personal and collective constructions of disability become conscious in the therapist's awareness. This awareness includes a fear of dependency, of imperfection, of being under-valued and of exclusion, fears that might otherwise become unhelpful unconscious projections. Working with learning disabled people requires that we have mourned our own idealised notion of the human condition, our own disappointed desire and our own yearning for a utopia in which illness, madness and imperfection are eliminated. It is then that we can facilitate the therapeutic process with an eye on new beginnings as I discovered in my work with Oliver.

Oliver was eight years old. He was diagnosed with a significant learning disability and attended a school for children with complex needs. Oliver lived with his mother and younger sister and had had no contact with his father since he left the family home when Oliver was three. Oliver had had a difficult beginning. His mother was attentive and supportive and struggled to manage his volatile behaviour at home. In school, Oliver was resistant to adult direction and the teacher experienced him as destructive in the classroom, displaying physical aggression towards adults and children. I remember feeling apprehensive about working with Oliver and in supervision found myself acknowledging the feelings of dread, as I wondered how I could open a welcoming psychic place for our work together.

Oliver's ability to express himself through his body became immediately apparent, despite his limited capacity to communicate through speech. DMP provided a non-verbal medium through which he could communicate issues that were potentially 'pre-verbal, unverbaised and unverbaisable' (Winnicott, 1971:130). In the first session Oliver avoided eye contact with me, ran straight to the play tunnel, dived inside and rolled from side to side. He shouted the word 'dark' from inside the tunnel. I sat nearby and wondered out loud if beginning our sessions together felt like being in a dark, perhaps frightening place. He became still and a finger poked out of the tunnel. Another followed and gradually a hand appeared and began to balance on its fingertips, hopping from side to side. The other hand appeared and a fight ensued. One hand lay defeated and limp on the floor while the other danced in victory. The fight resumed and the sequence repeated. Eventually the hands became locked in battle, both fell to the ground and were dragged back into the tunnel. The narratives enacted by his hands emerging from the tunnel, became a repeated feature of sessions. With the hand perhaps representing a 'symbol of human agency and ownership' (Leader, 2016:4), Oliver found a way to communicate his inner conflicts and struggles to locate himself in the world as a learning disabled child with little sense of his own agency. With his hands now disappeared back in the tunnel, I waited for what seemed like an age until Oliver slithered out of the tunnel. There was a look of apprehension on his face and I was taken aback by the intensity of the gaze that he fixed on me, projecting almost unbearable feelings of exposure. His serious expression turned into delight as he broke into peals of laughter. He grabbed the stretch cloth and handed one end to me, indicating that he wanted a game of tug 'o war. I held tight to my end and he too clasped his end of the cloth firmly. Our eyes met again and he began to jump, enjoying the tension in the cloth. He then let it go and as it fell to the floor, he ran forwards to pick it up and repeated the jumping. He repeated this sequence of clasping and letting go, keeping a close eye on my reaction.

These symbolic themes emerging in that first encounter held many of the rich and powerful symbols with which we worked in the ensuing months. The enclosed space of the tunnel became a place that Oliver explored the monsters of his imagination; those parts of himself that he wanted to keep hidden from me, perhaps through an unconscious fear that I would reject those 'monstrous' parts of him. In subsequent weeks, Oliver became a hungry monster thrashing around within the boundaries of the tunnel. The monster's voice was gruff and threatening, whilst Oliver's voice was weak and feeble as he shouted for help. Eventually Oliver was eaten by the monster who lay still, full-up and snoring. I spoke quietly to the monster and looked in the end of the tunnel. The monster gave an angry roar to frighten me away. I wondered out loud why the monster was so angry and what he might need. Oliver then curled up and closed both ends of the tunnel in the cloths that he had requested that I hang over each end to enclose the space. On this particular occasion, Oliver began to rock the tunnel from side to side, keeping it very close to me. I held the tunnel as it rocked until he was ready to push himself out. His fear of his capacity for destruction seemed to be expressed by the hungry monster and it was towards the end of the session that Oliver crawled out of the monster's stomach, leaving the monster in the tunnel, for me to 'look after' until the following week. Outside of the tunnel, the theme of holding on and letting go developed, alongside games of appearing and disappearing. So too explorations of falling and being caught and games of hide and seek became a common features. These games represented symbolic explorations of the rhythms of attachment and loss in a playing-out and replaying of the subtle dynamics of meeting each other in the intersubjective, potential space between us, providing an opportunity for some 'fine-tuning of (the) intersubjective field' (Stern, 2010:138). Further into the therapeutic process, Oliver left the safety of the tunnel and began to explore whole body movements of rolling and sliding, feeling his body in contact with the ground. We developed a movement relationship that involved leaning, pushing balancing and supporting. As I became

increasingly able to attune to his movements, so he became able to 'listen' to my response and we established a mutually understood embodied language.

Conclusion

This chapter offers a point of curiosity about how a learning disabled person is welcomed into the world. I am linking this fundamental primary experience to the dynamic, unconscious process between the DMP practitioner and the learning disabled client. Working in the transference harnesses the potential of the live enactment of early relationships in the immediate therapeutic relationship (Hernandez-Halton et al., 2000) and as such can offer a space for processing complex psychic material in relation to the lived experience of learning disability.

Beginning, like ending, is crucial to the therapeutic process and the facilitating environment can benefit clients best if it is enabling, empowering, welcoming and receptive to all that is there. The experience of entering the world for many learning disabled people brings with it those dynamics present in that initial diagnosis, in which the infant or child is met with disappointment and grief, rather than joy and expectation. This reflects a wider issue of inclusion in relation to the social, cultural and political participation of learning disabled people. As therapists, it's important to understand the dynamic process that is set up with a diagnosis in order to try to understand the complex nature of the disability transference. The diagnosis of learning disability is an opportunity to think about how to accommodate diversity rather than how to fix differences.

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