

Some Problems in Rehabilitation as Seen by a Lewinian

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I will talk about matters rooted in Kurt Lewin's early work with his students up to the time of his interest in small group research. During the 20's, I was his student in Germany, and took my Ph.D. with him. My thesis dealt with anger in frustration situations. Later, I was Lewin's assistant during his stay at Cornell and at the University of Iowa, until he arranged to move to the Massachusetts Institute of Technology. Ten days before he died, we were discussing psychological matters in Washington.

I am a Lewinian in my psychological thinking, emphasizing the *structural* characteristics of psychological occurrences. When Lewin once asked me, "Do you believe that topological properties *actually* exist in life?", I simply said "Yes." I felt then, as now, that much in life is spatial and structural.

Working with Lewin was a cooperative effort. In solving problems, the emphasis was on work rather than on individual performers. This was characteristic of Lewin's "Quasselstrippe"—the weekly meeting with his graduate students that began in Berlin. It characterized his daily—and daylong—meetings with his thesis students, as well as the frequent meetings of Fritz and Grace Heider, Eugenia Hanfmann, Lewin, and myself, in Massachusetts during Lewin's first years of residence in the United States. The Quasselstrippe meetings continued in the States and by then comprised a sizeable group of people interested in Topological Psychology. Characteristic of Lewin's approach was a complete involvement in the psychological

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task at hand, constant progress in finding solutions to problems, and the problems' close connection to everyday life. For many of us who were members of this group, this made the work on psychological problems a continuous scientific festival.

But my talk today is not a series of reminiscences; rather it can be looked upon as a progress report by one of the Lewinians on Topological Psychology.

Some of you may be familiar with the area of psychological rehabilitation of the deprived in which I've been working for a long time, and for others it will be a completely new psychological area. Therefore, I will have to proceed rather slowly, and perhaps I had better indicate what my final goal is, although I will only discuss the first steps. It involves values and value occurrences as a central problem. I would like to show that in the long run certain kinds of psychological values, namely, comparative values, which are dominant around us, are required for the understanding of the relation of non-deprived to deprived people in our society. Comparative values are used when people are accorded status along a scale of better and worse, rather than being regarded noncomparatively in terms of intrinsic values. Comparative values need to be studied because they determine a great deal in our lives, and are responsible for many difficulties that we all have. They become especially pronounced in the case of disadvantaged people.

To overcome the negative effects of comparative values, one has to change them. Such changes constitute a major part of the psychological rehabilitation of disadvantaged people. It implies also a shift from a personality approach to a social-psychological one.

Though my intent is to interest you in rehabilitation, some of you might be interested in other points I will touch upon, such as indications of the approach in this presentation, and of the new structural conceptualizations I try to introduce, e.g., *positional* characteristics of people.

STABILIZATION OF CONCEPTUALIZATIONS: HANDICAP, DISABILITY AND REHABILITATION

I believe that many basic rehabilitation ideas and terms require a stabilization of meaning. We can stabilize the terms by embedding them in a theoretical framework. The framework I will use is characterized by *structural and qualitative conceptualizations*. The basic terms used in rehabilitation psychology, such as handicap, disabled person, and psychological rehabilitation, must be stabilized, first of all.

Handicap and Devaluation

Let us start with the term "handicap."

The first question is a structural one. Where is a handicap located? People in everyday life, including many professionals, see the handicap *in* and as a part of the person who is considered disabled. If this is the case, then one would expect that psychological rehabilitation should also take place *in* the person. Such rehabilitation would traditionally take the personality approach, using counseling and therapy techniques. If, however, we locate the handicap elsewhere, then a different rehabilitation approach becomes feasible and perhaps necessary.

I believe that the handicapping conditions are *between* people, rather than *in* people, that is, the handicaps are located in interpersonal relations. A handicap requires at least two people in a certain relationship in which one person *considers* the other handicapped. This is what places the other in a handicapped position.

A pronounced emotional *qualitative characteristic* of this relationship is *devaluation* of the person being considered handicapped. The handicapping devaluation relationship has a donor—the devaluator—and a recipient—the one devaluated. In the *donor's eyes*, the recipient is devalued as a consequence of his or her loss or lack of valued possessions—loss of limb, loss of sight, etc. It is important that the devaluator does not see the loss as limited to one or a few of the devaluated person's functions. Rather, the devaluator spreads the loss over the entire person. The person considered handicapped is therefore seen as not good enough to be a friend, spouse, teacher, administrator—and is perceived somehow as a lesser human being in general.

What evidence leads us to locate these handicapping conditions in interpersonal relations? *Covert disrespect*—which the donor shows the recipient; *exclusion* of the person considered handicapped from decision-making, even in those matters that directly concern the person; considering these persons *inept* in general, even in matters having nothing to do with the disability.

Curiously enough, if the handicap is not *in* the person, then there are no handicapped persons. In other words, handicapped people exist only in the eyes of a viewer. Referring to someone as a "handicapped person" is then inaccurate, and stating that he or she "has a handicap" is misleading. We should instead say, "so-called handicapped people", or "people who are *considered* handicapped." This does not eliminate the problems the devaluated people face. Rather, it places the handicap, as well as psychological rehabilitation, somewhere else than *within* the so-called handicapped person.

If we ascribe the handicapping conditions to the devaluating relationship, at least two different options for psychological rehabilitation become feasible: a) to change the donor's (devaluator's) *personality properties* and way of evaluating people, or, b) to see the donor as a *representative* of the views of society. Does it make a difference whether we see the donor as a person acting on his or her own or as a representative of a culture? Yes, it does. For instance, if the donor believes that he or she *personally* imposes something negative on the recipient, the donor might feel responsible and guilty. But if the donor has the support of the cultural mores, it is far less likely that the donor will feel guilty. The social values provide the guides, and the donor subordinates his or her own values to them. It is similar to a soldier's ability, in wartime, to kill another human being—even though he or she could never kill anyone under ordinary conditions.

As mentioned before, we frequently act as *representatives* of our culture. This is no small matter. Every day we act toward others without taking their or our own observations and individual views into account. This can be easily seen in our dealings with strangers and with people who are considered disabled. First, let us consider strangers: We are expected to be polite, but we do not think we are obliged to be concerned about them, or take into account their views and desires, or feel responsible for their well-being. Strangers are also people we know nothing about. Their individual characteristics do not affect us. Our picture of a stranger lacks an experiential content, and we might therefore expect it to be blank. This has an important consequence: Since we have only cursory impressions of strangers, we are prone to *hearsay*—general cultural beliefs which we accept and apply without questioning. In regard to people who are considered handicapped, not only are many of them strangers to us, but in addition, due to our upbringing, we are supported further in our *estrangement* from them. Think how, as children, we were kept from people who were considered disabled. This widened our social distance from them. The hearsay to which we were especially receptive in this case was devaluative in nature, and it was strengthened and further promoted through estrangement.

We should take our relations with strangers, in everyday life and psychology, more seriously than we usually do. We should place more emphasis on children's relations, beliefs, and responsibilities toward strangers. By promoting knowledge, contact, and curiosity about strangers, we should be able to develop more positive *concern* by children for others, including people being considered disabled. Certainly, in this time and age, we need more concern for others in general, and more for the deprived in particular.

Let me summarize the structural changes so far. We began by considering the handicap as placed in isolation in the person considered disabled.

Then we changed, and considered the handicap in a more inclusive unit, that of interpersonal relations. We then shifted to a specific part of this unit—the donor who imposes his or her views. Finally, we examined the handicap in a very broad context—relations with strangers. In this way, we tried to determine some sources of devaluation leading to handicaps.

The devaluator further supports these views by selecting socially weak groups, and by making the groups weaker. Consider for yourself some of the devaluated groups: The physically and mentally handicapped, the chronically ill, old people, the poor, young children (who are not allowed to make decisions), minority groups, women (considered the weaker sex), people with criminal records (who are hampered by restrictions). The devaluator sees all these groups as weaker in different ways. For instance: they are considered socially less powerful or less valuable; they are denied the power of decision-making; and they have difficulty acquiring the tools needed to improve their actions and living conditions. They rarely reach influential positions.

Let us not forget: Decision-making and ways and means of improvement are in the hands of those who have power—the highly evaluated members of our society. They—not the people considered handicapped—determine the structure of the world in which the so-called handicapped live.

Disability As a Problem of Locomotion and Accessibility

The second basic conceptualization in rehabilitation is disability. Whereas the strictly medical view on disability implies the dysfunction of muscles, the deficiency in bones, and the disruption of nerve functions, disability is usually thought of as a person's total loss of particular skills, such as physical movements (in paralysis), communication skills (in deafness), or visual perception (in blindness). From the bearer's viewpoint, this is a misconception of the actual loss.

An analysis of disability in Rehabilitation Psychology should not only clarify the problems but also indicate their possible solution. This raises the question: Who is the person who judges what the problem is, and in what way does he or she think it can be solved?

Let us take as an example a person whose legs are paralyzed and examine his or her views (the views of the insider) as compared to the views of the outside observer. The impairment is seen in two different ways: (1) as an inability to move one's legs (this is usually how an outsider sees it), and (2) as an inability to get places (this is usually the insider's concern).

Outsiders see the disability as located in the body. They do not take the environment into account. They see the paralysis as inalterable, the person considered handicapped as immobilized and housebound.

The insider has a different view—he or she is eager to get to the doctor, the store, movies, or job. The insider looks for *a way to get there*—by means of a wheelchair, car, bus, van, anything. “Getting there” does not depend exclusively on the motion of one’s legs. One can be carried, *if* the terrain, stairs, and doorways permit it, *if* people are willing to carry you, or *if* they make devices accessible that can serve this purpose. It takes *effort* and *money* to make needed arrangements, but locomotion is feasible. If it is impossible in actuality, that is because of social conditions, and not because the person’s legs do not move. Quite simply, as people who are considered disabled look at it: Paralysis is a disability problem because outsiders who could provide a suitable environment do not do so.

It may seem that people who are considered physically or mentally disabled are the only devalued groups whose functioning is limited. This is not the case. The abilities of anyone can be limited by a devaluator. Disabilities can therefore be imposed on all devalued groups. Think, for example, about the hindrances women, old people, and ex-convicts face in acquiring jobs, or improving their situations in life. We learned long ago in Topological Psychology that locomotion is not restricted to physical movement. All goal-directed activities—whether bodily, cognitive, or emotional—require locomotion. All can face hindrances—barriers.

Let us not forget, however, that while outsiders are able to set barriers, they are also in the position to help make things accessible. They can impose handicaps, but they can also serve as rehabilitators.

Rehabilitation as Value and Emotional Changes in the Devaluator

The third and most crucial conceptualization that will be analyzed is Rehabilitation. It should be clear by now that both difficulties, handicap and disability, are social in nature. But we do not assert that all difficulties experienced by the so-called handicapped are social. Thus, physical or other difficulties do sometimes exist, and may require particular treatments such as physical therapy or speech therapy. Only indirectly, because the therapies mentioned involve interpersonal relationships, can social-psychological rehabilitation be useful in performing them. The emphasis in Psychological Rehabilitation is on the overcoming of barriers produced by social conditions. Devaluation affects all areas of everyday living, interpersonal relationships, and the administration of the affairs of the so-called handicapped. Further, we wish to emphasize the importance of social-emotional aspects of interpersonal relations and the values and feelings determining them. As a rehabilitation psychologist who must be *useful*, one has to help to overcome, or at least alleviate, the difficulties experienced by deprived

people due to devaluation, and it is important to analyze specifically what requires change.

We know that between realizing that a change is needed and actually bringing it about, it is necessary to specify the items, units, and constituencies implied. From the start of the analysis, though implicitly present, the single steps need to be explicated. This is what is involved in what one calls "determination of a problem" in science. Once a problem is determined in this way, it can become a workable scientific problem.

In regard to Rehabilitation, we are at the stage of determining the problems that need change, rather than being able to actualize Rehabilitation on a large scale. In other words, we are in the process of determining what is involved in the particular rehabilitation attempt, rather than being able to produce change wherever needed. Instead of just demanding that a change should take place, we are able to indicate some *specific* hindrances to change and some steps in overcoming them. I will briefly summarize a few of the steps that were discussed above.

1) First, in regard to rehabilitation of the so-called handicapped, instead of seeing rehabilitation as requiring change in the person who is considered disabled, we shifted the place of change to interpersonal relations.

2) Among the interpersonal relations, we specified the interpersonal relation of *devaluation* as the place of disturbance.

3) Devaluation was seen as an emotional relation as well as a value occurrence or process. The brevity of this presentation permits me only to indicate the kinds of values that become of special importance in the analysis of devaluation. They stem from the old, well-known Level of Aspiration conceptualization. This will be of special interest to those wondering how conceptualizations of Topological Psychology fare in our time.

4) The values pertinent to devaluation are comparative in character and are called comparative values. As in the Level of Aspiration phenomenon, these values are scaled. A higher position on the scale indicates a relatively higher status in regard to somebody else, and a lower position on the scale indicates lower status and relative devaluation.

If one would like *basically* to overcome devaluation in human relations, one would have to exclude comparative values from these relations. This raises the questions: What are values? Do *all* values require comparison? How can comparative values be changed to other types of values? Do intrinsic values, not needing comparisons, exist, and can they take the place of comparative values?

It is here where much thinking and research are needed. In the meantime, a step in regard to rehabilitation in relatively limited situations

might take place, namely, successful attempts can be made in diminishing the potency of the comparative standing or status of people by emphasizing, in any and all situations, *respect* for the person who is considered handicapped.

In our search, at the same time, we approached rehabilitation from another angle, that of disability. We also made a few steps easily, at first.

1) We realized that what was required to help the person was perceived differently by the sufferer (the insider), and the potential helper (the outsider).

2) We found that whereas the helper tends to disregard environmental conditions, the sufferer emphasizes that the problem does not lie in the inadequacy of his or her body as a tool, but in the neglect of diverse environmental conditions, such as ways of locomotion other than bridging distances between a person and his or her goal by walking.

3) We advanced, then, in understanding that provision of transportation is dependent on effort and money of those in power.

4) Further, we stated that *involving the outsider* in rehabilitation is necessary and that it depends on the willingness of the outsider to *give to others* in helping to solve difficulties of people who are considered disabled. Thus, we arrived again at an interpersonal problem.

How do we get people to be willing to give to others? Are we willing to help people who are devalued? Why aren't we? These are some of the issues.

We realized that disability and handicap were intricately connected by being parts of more inclusive social relations between those people who are in possession of means for alleviating some of the problems and those who do not have the means. We deal here with one of the inclusive social-psychological problems of the relation between the "haves" and the "have-nots."

At this place and time I cannot go into further analysis of value processes that are important for rehabilitation, nor into the analysis of the willingness of the "haves" to help the "have-nots" in our society.

Although we have made a few steps forward in determining what is involved in actualization of rehabilitation and indicated small improvements which can take place even at present, we know that we are not in a position to bring about the rehabilitation of the deprived on a larger scale, and have to work on it further.

CONCLUDING REMARKS

Those of you who want to know what was Lewinian in my talk may recollect:

- a) My stress, at several points, on structural and qualitative conceptualizations.
- b) The development of new structural, namely, *positional* conceptualizations.
- c) The fruitfulness of the Lewinian concept of locomotion, which includes any goal-directed activity.
- d) The outsider's power of setting up and removing barriers.
- e) The development of the scale of comparative values from the idea of the Level of Aspiration Scale.

Those especially interested in knowing what Rehabilitation has to offer Psychology in general, might think further about how positional conceptualizations might help us to understand interpersonal relations better by taking into account differences in donor-recipient views. One may see that positional conceptualizations determine one's observations and analysis of data, especially where evaluations are involved.

For Psychology in general, Rehabilitation is a perfect area in which to study emotional and value problems, for example, emotional relations such as compassion. When working in Rehabilitation, one must constantly consider values and conceptualizations of values. A person's loss of something valuable and the tendency to spread the loss is a pervading value problem. The relation to strangers and the emotional issues of concern are societal value problems. And certainly, the overcoming of devaluation is a value problem of major importance.

A Final Timely Remark

With Federal and State agencies re-evaluating their involvement in social issues, and the changes in responsibility for alleviating the problems of the deprived, not only economic and political values are being questioned, but psychological values as well. And I venture to say that psychologists are in dire need of a more comprehensive knowledge of everyday values. I would like to emphasize that the area of problems of the deprived, disabled, and devalued is central for understanding social psychological issues and value processes that face us here and now.