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Disability and the Counseling Relationship: What Counselors Need to Know

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Abstract

Disability is often misunderstood by counseling professionals and society. More often than not, persons without disability perceive it as a negative event and as something undesired, although this is not necessarily the experience or belief of many persons with a disability. Counselors that work with persons with disabilities and their families need to understand the experience and process of disability. Unfortunately, many counseling and psychology programs do not offer extensive training in this area. In an effort to enhance counselors' understanding and effectiveness when counseling persons with disabilities, the authors provide pertinent and relevant information to help individuals respond successfully and creatively to their disabilities.

Disability is an experience often perceived by persons without disabilities and society as a negative experience and as something undesired. Such attitudes are not necessarily the same as those held by individuals with disabilities and their families (Dunn & Brody, 2008; Wright, 1991); yet, it is the negative aspects of having and living with a disability that continues to be a primary focus and feature for people who do not understand disability (Smart, 2009).

Negative attitudes, beliefs, and associations extend beyond the general public. Indeed, even well-intentioned counseling professionals are subject to the effect of societal and historical beliefs pertaining to disability and may inadvertently contribute to the

perceptions of people with disabilities as diseased, broken, and in need of fixing without an understanding of this perspective. This may in turn negatively impact the counseling relationship with persons with disabilities and their families (Hartley, 2012). Compounding this reality is the fact that many mental health, school, and clinical counseling and psychology programs do not offer much training or knowledge related to the specific needs and experiences of persons with disabilities and this may equate to the provision of inadequate care (Stuntzner, Hartley, & Ware, 2014). For these reasons, counselors may find it beneficial to examine their own beliefs and expectations about disability, disability types, and anticipated outcomes when working with this population.

In an effort to help counselors improve their understanding, skill, and comfort level when addressing the diverse needs of persons with disabilities, Stuntzner and colleagues (2014) conducted a Pre-conference Learning Institute at the 2014 American Counseling Association Conference. Topics presented and discussed with session participants included the importance of

- using proper language to describe the person and the disability;
- identifying personal and societal barriers encountered by individuals with disabilities;
- devising a theoretical framework from which to understand adjustment to disability;
- learning counseling techniques to enhance therapeutic effectiveness; and
- being mindful of general counseling tips when working with persons with disabilities.

At the conclusion of this session, participants were provided an opportunity to apply the information they learned to a sample case study followed by a group discussion (Appendix A). An abbreviated version of this session is covered in the following sections to share with counseling professionals information deemed important and relevant to the needs of persons with disabilities and the counseling relationship.

The Language of Disability

Language, regardless of intent, is very powerful. It can be used to uplift or degrade someone "depending on how it is used" (Stuntzner, 2012, p. 40) and to convey attitudes toward others (Smart, 2009). Of particular importance is the awareness and consideration of terminology used to describe and refer to traditionally-marginalized groups, including persons with disabilities. Outdated or inaccurate words can encourage and promote, even if unintentional, poor and negative perceptions and feelings about persons with disabilities; some of which include the words "*invalid, suffering, afflicted, victim, handicapped, crippled,* and *wheelchair-bound* (Titchkosky, 2001, p. 127). Furthermore, language and repeated use of negative and disempowering words can influence the ways people view themselves, particularly when such experiences are internalized.

Language chosen by others may be affected by how they view themselves and the experience of disability. Disability scholars (Siller, 1976; Siller, Chipman, Ferguson, & Vann, 1967; Smart, 2009; Stuntzner, 2012) understand that negative perspectives held by persons without disabilities are about them, not persons with disabilities. Yet, the

rehabilitation counseling literature and research continues to stress the presence and promotion of negative attitudes and the reality that these personal and societal attitudes are conveyed through peoples' interactions. For example, people may (a) physically distance themselves from persons with disabilities due to their own personal discomfort, (b) experience increased anxiety when confronted with the prospect of disability, (c) ascribe negative personality traits toward persons with disabilities, or (d) fear the possibility of it happening to them which also creates additional distance (Siller et al., 1967).

Counselors that work with individuals with disabilities and/or their families should be aware of the impact of historical and societal perceptions toward disability and how that affects societal beliefs (see Rubin & Roessler, 2008). In addition, counselors have a professional responsibility to be cognizant of their own word-choice and use of terms when referring to persons with disabilities and its potential impact. More specifically, they need to be mindful of whether they view the person as an individual who has the same rights, needs, and desires as anyone else or if they perceive him as incapable, weak, less than, suffering, pitiful, handicapped, or physically/mentally challenged and so forth (Smart, 2009; Titchkosky, 2001).

Counselors are encouraged to learn more about appropriate terminology including the use of "person-first" language. Although this is not a perfect system, it represents where the profession is at the moment. In most instances, persons with disabilities may be referred to as just that or as "individuals with disabilities" (Falvo, 2009). Perhaps, a more suitable and appropriate way to refer to persons with disabilities is simply by their "first name"; however, this is often not what takes place. In all of these instances, the focus rests on recognizing and valuing the fact that each individual is a person first and foremost with many endearing qualities and of which disability comprises only one feature. Complicating these guidelines is the fact that some people living with a disability have other preferences and ways for identifying and describing themselves. In these instances, counselors should be sensitive to the terms used by the person served, yet not assume that this "chosen term" is how they can refer to her. When unsure of how to proceed, counselors should ask the person with a disability about his or her personal preference.

A final area worthy of consideration is that of personal sensitivity. Stuntzner and colleagues (2014) introduced a visualization exercise, which has been used previously in trainings, to enhance understanding of and sensitivity to disability. During this exercise, participants were asked to remember a time in their life that they found personally challenging, emotionally painful, and would not want to relive. Throughout the visualization, participants were asked to experience, in detail, their thoughts and feelings and to remember vividly this past event. At its conclusion, participants were asked to reflect on and share with the group what this experience was like, how they would feel or think about themselves if this experience followed them for life, like a paper trail, and was a greatly misunderstood situation that they could never rid themselves of regardless of where they went.

Barriers Encountered by Individuals and Families With Disabilities

Counselors can enhance their understanding and knowledge of issues relevant to the needs of persons with disabilities and their families by learning about the various forms of personal and societal barriers they often encounter. Of particular importance is for counselors to collaborate with their clients to (a) identify which barriers are most salient, (b) examine the ways the identified barriers inhibit their functioning or prevent them from coping more positively, (c) explore which ones are within their control to change, and (d) determine strategies they can use to cope with and move past them. This process is not always easy, nor is it particularly linear, and may require some time and effort to resolve.

Throughout this process, counselors who do not regularly work with individuals with disabilities first need to become aware of the fact that such barriers are a reality, even if they cannot visually see or understand them. Common barriers referred to through personal accounts and the rehabilitation literature stress the fact that many individuals, regardless of disability type, face attitudinal, architectural, environmental, medical, employment, access, and personal barriers. Within each of these categories exists a plethora of additional barriers, some of which may overlap and are provided in Appendix B. Having such knowledge is essential because individuals may be looking to counselors for support and guidance when they do not yet know how to proceed. Complicating the situation is the fact that many individuals with disabilities are not given proper exposure, training, or information pertaining to the existence of societal barriers. Oftentimes many do not receive self-advocacy skills training while in school or later in life. As a result, they are on their own to figure out how to best make sense of their experiences and to develop the skills they need to move beyond them (Stuntzner, in press).

Once the most cumbersome and problematic barriers have been identified, counselors can assist individuals in uncovering the ways such barriers impact their life and in determining which ones they can change. Such a process requires counselors to work collaboratively with their clients to differentiate between *self-imposed* versus *other-imposed* barriers (Stuntzner, in press). *Self-imposed barriers* refer to those experienced by individuals with disabilities, partly in effect, because they are thinking or behaving in ways that contribute to their existence. For instance, individuals may have been told they are not capable of something and start to believe it. As a result, they feel disempowered, become consumed with negative feelings such as apathy or withdrawal, and end up feeling victimized. As a result, they do not behave in ways to help themselves address or move past these negative messages. *Other-imposed barriers* refer to those created or placed upon individuals with disabilities by other people, agencies, entities, or society. Examples of other-imposed barriers include: negative societal barriers, employers' resistance of hiring individuals with disabilities, and lack of access to public buildings due to non-accessible architectural structures. In many instances, reported barriers represent a composite of self- and other-imposed barriers. More specifically, these are those times when someone else imposes a barrier, initially, and this obstacle is further impacted by the practice and implementation of a personally self-imposed barrier. When this occurs, counselors can assist individuals in determining their part in the issue and in selecting strategies to better cope with the presented barrier.

Exploration of Adjustment to Disability

Adjustment to disability is another area of relevance to individuals with disabilities and the counseling relationship. Counselors who counsel individuals are encouraged to understand the meaning of adjustment, factors which may influence its development and occurrence, and theoretical models of adjustment to disability to provide context to the experience of coping with disability. The process of learning such knowledge and being able to effectively integrate it requires effort on the counselor's part, especially given the fact that most counseling and psychology programs do not offer extensive training in such areas. Nonetheless, understanding adjustment to disability and theoretical models that help explain the adjustment and adaptation process are very useful.

Understanding Adjustment to Disability

Adjustment to disability is a phrase used to describe the way individuals are coping and functioning while living with a disability. More specifically, it may refer to the thoughts, feelings, and behaviors of individuals who are trying to reach a place of acceptance and personal integration of the disability into their self-concept. Oftentimes, adjustment to disability is conceptualized as the final phase of accepting one's disability and in moving forward with one's life (Livneh & Antonak, 1994; 1997; 1999). Other times, it is interchanged with the phrase adaptation to disability although the latter typically deals more with the process that occurs gradually and continually in an effort for individuals to achieve an optimal state of being or personal and environmental congruence (Livneh & Antonak, 1997). Of most relevance to counselors is the understanding that adjustment to disability takes time and usually involves some sort of adaptation process which hopefully leads to better functioning and outcomes for individuals with disability.

Factors Influencing Adjustment to Disability

Factors known to influence adjustment to disability are many and are used by counseling professionals to better understand "the probability of successful versus unsuccessful adjustment" (Stuntzner, 2008, p. 7). Those factors that are most salient to each individual may vary; however, counselors need to be cognizant of what they might be. Some of the factors associated with adjustment to disability discussed throughout the rehabilitation literature include (a) depression (Livneh & Antonak, 1997; Skinner, Armstrong, & Rich, 2003), (b) locus of control (Livneh, 2000), (c) spirituality (Byrd, 1997; Longo & Peterson, 2002), (d) self-blame or unresolved feelings for cause of disability (Buckelew, Baumstark, Frank, & Hewett, 1990; Nielson & MacDonald, 1998), (e) negative feelings and emotional distress (Lane, 1999), (f) self-esteem (Wright, 1983), (g) coping strategies (Livneh, 2000), (h) social support, (i) gender (Nosek & Hughes, 2003), (j) age of onset (Crewe, 1999; Trieschmann, 1988), (k) familial support (Crewe, 1999), (l) socioeconomic status and financial health (Trieschmann, 1988), (m) level of education and employment (Livneh & Antonak, 1997), and (n) societal attitudes (Trieschmann, 1988). Other factors discussed by Smart (2009) included the meaning one ascribes to the disability, severity of disability, visibility versus invisibility of the disability, and the amount of stigma experienced and associated with the disability.

Models of Adjustment to Disability

Numerous models have been developed and written to explain the process of psychosocial adjustment to disability. Among the plethora of models available are those categorized as early psychosocial models, medical and educational models, stage models, integrated models, ecological models, and chaos theory (see Stuntzner, 2008, for full review). Counselors can enhance their understanding of the adjustment to disability process by becoming familiar with these models. Two models of adjustment to disability that may be of particular interest to counselors are Wright's (1983) psychosocial model and Livneh and Antonak's (1997) stage model of adjustment.

According to Dembo, Leviton, and Wright (1956), and later by Wright (1983), the adjustment to disability process was believed to be affected by an individual's ability to: (a) enlarge or alter one's personal values following disability, (b) live a life that is not dictated by the disability, (c) focus on one's strengths and values rather than comparing oneself to others, and (d) live in a way that does not focus entirely on one's physical or personal appearance. Wright also helped counseling professionals understand that some people experience a sense of loss following their disability; thus, they may have a desire to make sense of it or to find meaning. Furthermore, through her work, Wright stressed that individuals must learn to view themselves as a whole person who has many attributes and abilities for successful adjustment to occur.

Disability scholars Livneh and Antonak (1997) developed a stage model to explain the process of adjustment to disability. Their model views adjustment to disability according to eight stages: (a) Shock, (b) Anxiety, (c) Denial, (d) Depression, (e) Internalized Anger, (f) Externalized Anger and Hostility, (g) Acknowledgement, and (h) Adjustment. Collectively, this model proposes that individuals may experience some or most of the first six stages, which comprises negative thoughts and feelings, before they reach a stage of acceptance and adjustment. However, they also stress the fact that adaptation may not take place in a linear fashion, adjustment phases may be skipped or later revisited, individuals' reactions will vary from one another, and each phase does not occur according to a pre-determined amount of time.

Regardless of the chosen model, counselors need to be aware that one model does not fit all experiences of disability or the needs of all individuals; therefore, the more knowledge counselors have about the adjustment to disability process, the better equipped they will be to select models they can use to explain the coping process of their clients.

Techniques for Counselors to Enhance Effectiveness

Beyond the many personal and societal issues and the coping and adaptation to disability process, are the techniques and strategies counselors may incorporate into the therapeutic relationship. The techniques proposed in this section are not necessarily connected with specific counseling approaches or theories; however, many of them focus on changing a person's thoughts, feelings, and behaviors in relation to themselves, others, or God. Furthermore, some approaches have been empirically studied and are known to reduce negative thoughts and emotions (i.e., forgiveness, self-compassion) or are discussed extensively throughout the literature as essential skills for living well with a disability (i.e., resiliency, self-advocacy, self-concept).

Counselors that want to use and integrate the following techniques can consider using them as individual techniques or interventions or as supplements to their theoretical paradigm. Therefore, the focus in this section is on primarily introducing topics and approaches that can be used to change the way persons with disabilities think, feel, or act in situations related to the presence of their disability.

Forgiveness, self-compassion, and resiliency are three constructs which have been empirically studied. More specifically, forgiveness and self-compassion have been shown to reduce negative emotions and improve overall functioning and well-being (Enright, 2001; Neff, 2011). Both constructs and approaches have much relevance to the lives of persons with disabilities due to the magnitude of negative experiences and treatment faced by persons with disabilities. Furthermore, resiliency is an identified skill which has been found to have much relevance to the needs and issues of persons with disabilities and may be taught to enhance functioning (White, Driver, & Warren, 2008).

Counselors interested in teaching their clients forgiveness are afforded access to intervention approaches such as Enright's (2001) forgiveness process model. Those interested in teaching self-compassion can use Germer and Neff's (in press) self-compassion intervention following its release. In the meantime, trainings on self-compassion are offered to professionals wanting to know more about how to teach self-compassion (www.self-compassion.org). Both of these interventions can be used to teach clients essential skills pertaining to forgiveness and self-compassion as it relates to coping, adaptation, and self-acceptance. Interventions that can be used to teach resiliency-based skills are still unfolding. Stuntzner and Hartley (2014) are currently developing a resiliency-based intervention for persons with disabilities; however, counselors may also construct ways to teach clients specific skills known to influence and enhance resiliency (i.e., social support).

Counselors may also use techniques pertaining to dealing with difficult emotions, redefining self-concept and self-identity, learning how to self-advocate, and integrating the skills learned to become more empowered. Many strategies and techniques related to these topics were covered as a part of the Pre-conference Learning Institute and are very relevant to the coping and adaptation process of persons with disabilities.

Counseling Tips for Professionals

A final area worthy of mention is the general counseling tips that all professionals who counsel persons with disabilities should keep in mind and practice. Counselors who are mindful of these tips will increase their chances of developing an effective therapeutic relationship and understanding of persons with disabilities. Many of the tips discussed by Stuntzner (2012) are simply based on common sense and related to the art of treating persons with disabilities with respect and as human beings the same as anyone else. Some of the counseling tips she stressed include:

- being mindful that the expressed negative experiences related to disability are real;
- considering the effects that labels may have on your clients (Smart, 2009);
- treating persons with disabilities as human beings rather than as their disability;

- building awareness of your own attitudes and biases which may affect the counseling relationship;
- being aware of how persons with disabilities describe themselves;
- respecting the fact the persons with disabilities know their own bodies and experiences;
- getting the necessary training and supervision needed to effectively counsel persons with disabilities;
- paying attention to the abilities and strengths of persons with disabilities and incorporating them into the counseling relationship;
- recognizing that most persons with disabilities do not live their life "focusing" on their disability and limitations;
- identifying counseling topics which make you uncomfortable (i.e., sexuality and disability) so you can address these; and
- being willing to have an open mind to the shared experiences within the counseling relationship.

Conclusion

Disability is an experience typically misunderstood by many, including counselors and professionals who don't work much with this population. To change this trend, key points and essential information counseling professionals should know were discussed. Counselors who employ this information and these recommendations as a part of their therapeutic relationships, open themselves up to the possibility of learning about the experience and "voice" of disability. Such efforts have the potential to benefit persons with disabilities, the counseling professional, and the therapeutic relationship.

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Note: This paper is part of the annual VISTAS project sponsored by the American Counseling Association. Find more information on the project at: http://counselingoutfitters.com/vistas/VISTAS_Home.htm

Appendix A

Case Study Sample

Belinda is a 20-year old female. Eight months ago, on the way home for summer break from college, she was in a multiple car wreck due to a drunk-driver passing her. As a result of this wreck, Belinda sustained a spinal cord injury, a mild Traumatic Brain Injury, and a broken left wrist. At last report, there were no injuries to the other driver. When she comes to see you, her wrist has healed and she continues to participate in out-patient physical therapy twice a week.

Belinda comes to see you for counseling because she notices several personal issues and concerns starting to surface and reports feeling discouraged, angry, and overwhelmed. Prior to her accident, Belinda completed her first year of college and was taking core classes required of all students, but expresses an interest in business. In addition, she states that her boyfriend of 3 years has left her because he does not want to deal with her "situation." She has also noticed some so-called close friends disappearing one-by-one. Furthermore, her father is not handling her injury very well and from time-to-time makes negative and hurtful comments about her disability and her ability to not yet be fully independent. He also, on occasion, when he thinks she is not listening, makes comments to her mother that "No one will ever probably want to marry her…" Complicating matters is the notion that her parents ascribe her accident as something negative due to the fact that they are highly religious and do not feel they have done anything to deserve this.

At the end of your initial session, you realize there are probably many more layers of this story and of emotional hurt which has not surfaced and Belinda is in tears as she continues to express feelings of guilt and shame. Before Belinda leaves the session, she wants you to know that she desires to cope better and have a better way of life; however, she is surrounded by all this negativity and feels as if she has little support.

1. Given what you know about Belinda, what else would you like to know so that you can best help her heal and move beyond her disability?

2. What are Belinda's primary issues and concerns? How would you determine which areas to address first?

3. Identify the potential barriers Belinda may encounter as she tries to heal.

4. How might you help her deal with probable differences in expectations held by herself and those of her family and others around her?

5. What counseling techniques do you think would be most relevant to Belinda's situation? Explain your rationale.

6. What is a good outcome goal for Belinda?

Appendix B

Table I

Examples of Personal and Societal Barriers

Categories of Barriers	Specific Barrier Types	Overlap Potential
Societal Barriers		
Attitudinal (A)	Societal stigma regarding disability	Yes (E, E, I, F)
	Inaccurate beliefs/myths	Yes (E, E, F)
	Professionals' attitudes and beliefs	Yes (E, E, I, F)
	Perceptions as 'second-class' citizens	Yes (E2, I, F)
Environmental (E/E1)	Lack of access to buildings	Yes (E2, I, F)
	Lack of access to public parks	Yes (I, F)
	Inaccessible transportation	Yes (E2, I, F)
Employment (E/E2)	Employers' beliefs about disability	Yes (A, E1, I, F)
	Employers lack of willingness to hire people with disabilities	Yes (A, E1, I, F)
	Health & medical insurance	Yes (I, F)
Personal Barriers		
Individual (I)	Self-concept/Self-belief	Yes (A, E2, F)
	Feelings of powerlessness	Yes (A, E2, F)
	Lack of disability knowledge & self-advocacy skills	Yes (A, E, E, F)
	Poor societal treatment	Yes (A, E, E)
	Changes in independence	Yes (A, E, E, F)
	Financial health & wealth	Yes (A, E2, F)
Familial (F)	Societal attitudes & service coordination	Yes (A,E2,I)
	Familial expectations & beliefs	Yes (A,I)
	Family cohesiveness & resiliency	Yes (A, I)
	Loss of family income & resources	Yes (A,I)