DISABILITY AS DIVERSITY: EXPLORING THE PSYCHOTHERAPY EXPERIENCES OF PEOPLE WITH DISABILITIES

by

DENISE POWERS

(Under the Direction of Edward Delgado-Romero)

ABSTRACT

The disability community is the largest minority group in the U.S. and includes an extensive range of experiences including physical, sensory, cognitive, and psychological conditions. Social science researchers have made continuous calls for research to approach disability as a diverse, marginalized community with unique experiences and needs in mental health treatment (Bogart & Dunn, 2019). The current study expanded on previous studies by exploring the individual psychotherapy experiences of adults with any disability. A qualitative approach guided by phenomenology and social constructivism was conducted with 7 individuals who identified as disabled and had previously or were currently engaging in psychotherapy. Reflexive Thematic Analysis (Braun & Clarke, 2019) was utilized to analyze the participants' responses. Results highlight how the multi-faceted experience of living with a disability, mental health clinicians' approach to centering disability, level of disability competence, and environmental and institutional factors shaped the participants' psychotherapy experiences.

INDEX WORDS: Psychotherapy; people with disabilities; diversity; Phenomenology

DISABILITY AS DIVERSITY: EXPLORING THE PSYCHOTHERAPY EXPERIENCES OF PEOPLE WITH DISABILITIES

by

DENISE POWERS

B.B.A, University of Georgia, 2009

M.Ed., University of Georgia, 2019

A Dissertation Submitted to the Graduate Faculty of The University of Georgia in Partial Fulfillment of the Requirements for the Degree

DOCTOR OF PHILOSOPHY

ATHENS, GEORGIA

2024

PSYCHOTHERAPY EXPERIENCES OF PEOPLE WITH DISABILITIES

by

DENISE POWERS

Major Professor:	Edward Delgado-Romero
Committee:	Collette Chapman-Hilliard Alan Stewart

Electronic Version Approved:

Ron Walcott
Vice Provost for Graduate Education and Dean of the Graduate School
The University of Georgia
August 2024

DEDICATION

This project is dedicated to the participants who entrusted me with their stories, experiences, vulnerabilities, hurts, and joys. I hope that this project honors your experiences and moves the needle forward in creating affirming and supportive spaces for the future generations of disabled individuals seeking psychotherapy.

ACKNOWLEDGEMENTS

I wish to extend my deepest and heartfelt gratitude and appreciation to the community of loving and supportive individuals who made this project possible. To my loving friends, Stephanie and Chris: thank you for believing in me in the hours when I did not believe in myself, for the endless hours, days, and years of support, and for providing a foundation to stand on. Stephanie: thank you for reminding me of my inner strength and for seeing me in ways that I could not see myself. Chris, thank you for the endless meals, nighttime dog walks, words of encouragement, and presence. Throughout the times where I felt incredibly unseen elsewhere, you were there. To my family, thank you for supporting me from afar even though it wasn’t always clear exactly what I was devoting so much of my life to. Mom, thank you for the endless snail mail, words of encouragement, and virtual hugs. To my Atlanta family, BJ and Linda, thank you for game nights, holiday get-togethers, and a space to remain grounded and centered outside of academia.

To Dr. Edward Delgado-Romero: thank you for seeing my potential as a researcher and clinician, and for taking me on as a student during a time that I very much doubted myself. Thank you for the words of encouragement, texts, phone calls, emails, and last-minute meetings. To Dr. Collette Chapman-Hilliard: you were my inspiration for pursuing a doctorate. Thank you for pulling me aside that fateful day, asking me what my next steps were, and planting the seed. Thank you for valuing my contributions as a student, researcher, and clinician. I am better, in countless ways, because of the way you made me feel seen. To Dr. Stewart: thank you for the

ways you supported my exploration of disability-related topics through classrooms and for your endless supportive feedback on my work. I still refer to your comments on my papers to this day.

To my peers and mentors at the University of Georgia, thank you for the ways you advocated for disability-related issues both personally and professionally. Thank you for an affirming space and continual reminders that my experience had a place to be seen.

And finally, to Sarah, my therapist: because of you, I understand what it means to feel whole, safe, and strong enough to undertake difficult things. Thank you for seeing and embracing all parts of me with curiosity, compassion, and unwavering tenderness.

TABLE OF CONTENTS

Page

CHAPTER

APPENDICES

LIST OF TABLES

Page

LIST OF FIGURES

Page

CHAPTER 1

Introduction

Background and Context

The disability community is the United States' largest minority group, and it is estimated that over a billion people globally live with a disability (World Health Organization [WHO], 2021). Disability encompasses an extensive range of physical, sensory, cognitive, and psychological conditions that are associated with unique physical and socioemotional experiences. Given the impact of the COVID-19 pandemic, the incidence of both temporary and long-term disabling health conditions is increasing given the long-term effects of infection (Center for Disease Control and Prevention [CDC], 2022a; Smith, 2022).

Historically, the disability community has experienced sociopolitical oppression similar to other marginalized populations (Bogart & Dunn, 2019; Charlton, 1998; Olkin, 2017). Despite the heterogeneity of experiences within the disability community, literature shows that society holds pervasively negative attitudes towards the disability community (Keller & Galgay, 2010; VanPuymbrouck et al., 2020). Furthermore, people with disabilities (PWD) have been uniquely and negatively affected by the ongoing COVID-19 pandemic (Lund et al., 2020; Shakespeare et al, 2021). Given the negative effects of ableism (Dovidio et al., 2011; Kamalakannan et al., 2021; Kattari, 2020; Wilson & Scior, 2014) as well as the challenges and barriers PWD have faced throughout the COVID-19 pandemic (Cochran, 2020; Kendall et al, 2020; National Council on Disability [NCD], 2021) mental health providers must be prepared to competently work with clients with disabilities.

In addition to being a marginalized group, the disability community is also a cultural group characterized by shared experiences occurring in sociopolitical, economic, legal, and educational spheres (Olkin, 2017). Disability culture is also undergirded by values centered on acceptance of human difference, pride in identity, interdependence, resilience, humor, and an orientation towards the future (Gill, 1995, 1997; Gilson et al, 1997). Shared language in the disability community particularly around identity (e.g., deaf versus Deaf, chair user, and person-first versus identity first-language) reinforces the belief that disability is not organized around impairment, though that is an important aspect of the disability experience, but about pride in pushing against traditional, deficit-based conceptualizations of disability (Gill, 1995; Olkin, 2017). Advocacy and activism within and for the betterment of the community are central organizing principles and are evident throughout the disability rights movement (e.g., 504 Sit-in).

A handful of studies have explored the therapy experiences of people with disabilities and demonstrate how disability-related issues are intertwined with mental health and the therapeutic process (Conner et al., 2023; Evans & Randle-Phillips, 2020; Hunt et al, 2006). However, given the changing sociopolitical conditions with the ongoing COVID-19 pandemic, the increased need for mental health services, and ongoing calls for psychology to increase scholarship regarding people with disabilities, a qualitative inquiry into the therapeutic experiences of people with disabilities is warranted.

Definitions

Disability: An umbrella term that refers to physical, sensory, cognitive, and psychiatric conditions. Both discernable and non-discernable disabilities are included along with chronic health conditions not typically categorized by society as disabilities (e.g., Crohn’s Diseases, HIV/AIDS, Fibromyalgia) as well as rare medical conditions and undiagnosed/undiagnosable conditions (Bogart & Dunn, 2019).

Persons with Disabilities / Disabled Persons: Persons with disabilities comprise both those who self-identify as disabled as well as those who society deem disabled. While professional organizations suggest using person-first language (person/people with disabilities), advocates and scholars within the disability community have argued that identifying as “disabled” is not inherently negative (Dunn & Andrews, 2015). Thus, these terms will be used interchangeably throughout this manuscript.

Ableism: Set of attitudes, beliefs, and behaviors that underlie prejudicial and discriminatory practices towards people with disabilities. Ableism rests on the assumption that there is a “normal” way for the body to operate and that any deviation from this norm is considered deviant and undesirable. A person’s value and worth are considered to be compromised if they are perceived by others as disabled.

Justification of Present Study

Within psychology, disability has historically been conceptualized from a deficit-based perspective (Goodley & Lawthom, 2006), and researchers have urged psychologists to embrace the disability community as a diverse, marginalized community with unique experiences and needs in mental health treatment (Bogart & Dunn, 2019; Olkin, 1999, 2002; Olkin & Pledger, 2003). Despite a wave of activists and researchers dating back to the 1960s calling for the acknowledgment of society’s role in PWD’s lives, psychology has largely emphasized the individual nature of disability while ignoring social and systemic factors (Olkin & Pledger, 2003). Bogart and Dunn (2019) renewed the call to action for psychology to embrace the many facets of the disability experiences and provided an in-depth exploration of the deleterious effects of ableism.

Along with psychology's harmful conceptualization of disability, studies show how mental health clinicians receive little to no education and training on counseling PWD (Olkin, 2002; Parritt & O'Callaghan, 2010; Rivas, 2020; Rivas & Hill, 2018). Olkin (1999) found that from 1989 to 1999, the number of disability courses in American Psychology Association-accredited clinical psychology decreased despite the passing of legal and professional guidance such as the American with Disabilities Act of 1990 (ADA) and the APA Task Force on the Psychology and the Handicapped (1984). Without foundational education and training, non-disabled mental health clinicians are unprepared to competently engage in cross-cultural counseling when working with PWD.

Therapeutic work with people with disabilities has largely been considered a specialization that rehabilitation professionals engage in even though most mental health clinicians will work with disabled clients at some point in their life. Psychological scholarship regarding disability-related issues is also scarce. Within Counseling Psychology, an analysis spanning 20 years (1990-2010) found that only 55 out of the 4,371 articles (1%) published in the four top Counseling Psychology journals covered disability-related topics (Foley-Nicpon & Lee, 2012). This study aims to contribute to the paucity of scholarship on disability-related issues.

APA asserts that marginalized group membership has implications for the therapeutic process, and clinicians must consider how diverse identities impact a client's social, emotional, and psychological well-being (APA, 2017). While researchers have studied the phenomenon of counseling clients with disabilities from a clinician's perspective (e.g., Rivas & Hill, 2018), there is a paucity in scholarship exploring the counseling experience from the disabled client's perspective. Rivas & Hill (2018) found that counselors-in-training struggled to provide effective treatment for PWD due to feelings of shame, anxiety, inadequacy, and discomfort as well as factors including incomplete training, inconsistent exposure to PWD, and harmful conceptualizations of disability. Furthermore, they reiterated the need for additional research on counseling experiences from the client perspective to bolster how education and training programs are developed.

Hunt and colleague's (2006) qualitative study of the counseling experiences of lesbians with physical disabilities illustrates the importance of capturing the client perspective. The researchers interviewed 25 women about their experiences and gleaned important data around how to improve counseling lesbians with physical disabilities. Resulting themes included level of satisfaction with the counselor, perceived counselor effectiveness, awareness and education on issues related to their intersection identities, experiences of discrimination and bias, and navigating difference aspects of the counseling process including coming out, advocacy, and accessibility. The researchers noted that the implications of their study may not be generalizable to non-lesbian clients with physical disabilities or clients with disabilities that are non-physical in nature (e.g., sensory, psychiatric, etc.).

Another study by Conner and colleague (2023) explored the psychotherapy experiences of U.S. adults with the goal of identifying disability affirmative approaches supported by scholarship. 24 people (21 women, 3 nonbinary individuals) were interviewed for the study which produced four domain themes: positive and negative therapeutic interactions and interventions, accessibility or inaccessible treatment, and suggested ways to improve treatment. The results of their study suggested that disability affirmative treatment from their participants' perspective paralleled values of disability culture including embracing diversity, shared vulnerability, and flexibility. The authors acknowledge that generalizability of these results are limited since the majority of the participants were cisgender women and highlight the need for studies exploring the counseling experiences of men, LGBTQ, and people of color living with disabilities.

The overwhelming evidence that psychology underprioritizes disability as a dimension of diversity and psychosocial importance in mental health education and training along with the shockingly low number of studies exploring the counseling experience from the client perspective emphasize a strong need for in-depth exploration of the counseling experiences of people with disabilities.

Purpose Statement

The disability community may be one of the largest yet understudied minority groups in psychological research. The lack of training and education that mental health clinicians receive along with the paucity of research in general around the counseling experiences of PWD point to an urgent need for development of psychological research that addresses this gap. While researchers have made significant and important conceptual contributions regarding disability-related issues that mental health clinicians must consider when working with people with disabilities, the client perspective has been largely ignored. As is common in many spaces that historically address disability, research has been conducted *on* disability and *for* people with disabilities but rarely *includes* people with disabilities as the co-creators of such research. As Roberts, a pioneer in the disability rights movement noted, “If we’ve learned one thing from the civil rights movement in the U.S., it’s that when others speak for you, you lose” (Driedger, 1989, p. 28). This study aims to bring the experiences of the community to the forefront, allowing their stories and words to directly contribute to psychological research. In other words, *nothing about us without us*.

Research questions

The following questions will guide this qualitative study.

1. What are the experiences of people with disabilities in individual therapy settings?
2. What, if any, is the essence of counseling that people with disabilities perceive and describe as helpful?
3. What, if any, is the essence of counseling that people with disabilities perceive and describe as unhelpful?

Chapter 2

Literature Review

Disability has been a natural occurrence since the dawn of human existence. Whether occurring pre-birth, throughout development and the lifespan, or resulting from environmental and external factors, disability is a dynamic aspect of the human experience. Identifying as disabled, compared to other social identities, is unique in that it can be a temporary identity as well as one that is acquired later in life. Defining and conceptualizing disability changes depending on who is addressing it or trying to research it. Thus, conceptualization of disability largely depends on the context it is situated within, and because of this, who is deemed disabled is likely to fluctuate. Social researchers are encouraged to embrace disability as a matter of human diversity (Bogart & Dunn, 2019) and move away from a medicalized conceptualization (Olkin, 2002). In this study, disability is viewed as an aspect of human diversity and encompasses a large umbrella of physical, sensory, cognitive, and psychiatric conditions. Chronic illnesses (e.g., those living with illness related to COVID-19 infection and health conditions as well as rare disorders and undiagnosable disorders are included. Furthermore, both those who self-identify as well those who are perceived as disabled by society are included.

In the United States, approximately 1 in 4 (24.8%) citizens over the age of 18 are living with at least one disability (CDC, 2022a). Globally, over a billion people live with some form of disability (WHO, 2021), and the reality of the COVID-19 pandemic and long-term health effects from infection will most likely increase the prevalence of disability. The American Academy of Physical Medicine and Rehabilitation (AAPM&R) tracks incidence of long covid (technically known as Post-Acute Sequelae of SARS-CoV-2 [PASC]) and estimates that over 28 million people in the United States are living with PASC (AAMP&R, 2022). The prevalence of PASC has the potential to permanently alter the way disability is viewed in the U.S. given the significant impact on daily functioning of PASC including barriers to work and receiving proper healthcare (Stead Sellers, 2022).

Literature shows that, despite continued calls for increased education and training of mental health providers on disability-related issues, clinicians are often ill-equipped to properly address disability-related issues in therapy (Hunt et al., 2006; Olkin, 1999; Rivas, 2020; Rivas & Hill, 2018). Olkin (2002) argues that when non-disabled clinicians are working with PWD, they are engaging in cross-cultural therapy without the appropriate knowledge, skills, and awareness to competently guide conceptualization and treatment. Limited research (e.g., Hunt et al., 2006; Evans & Randle-Phillips, 2020) explores the client perspective. This lack of perspective negatively impacts the training and competence of mental health clinicians.

Discrimination and Oppression in the form of Ableism

The societal oppression of PWD extends deep into history, and it has been theorized that ancient Greek societal ideas regarding human perfection contributed to negative conceptualizations about disability. Scholars argue that Greek society had a variety ways of viewing disability that encompassed religious, medicalized, and social perspectives and that being perceived as disabled posed potentially devastating consequences (e.g., expectations to overcome disability to participate in warfare, social exclusion, shame to one’s family, and death by infanticide; Penrose, 2015). Modern U.S. society fluctuates between viewing disability as an aspect of morality, of biological impairment, or of social construction depending on cultural, geographic, and sociopolitical positionality (Olkin, 2017).

As Charlton (1998) notes, PWD's experiences with oppression "is itself most often a partial experience of oppression" (p. 10) in that PWD may also concurrently experience racism, sexism, classism, and other forms of oppression. It is important to emphasize that holding intersecting marginalized identities influences how ableism is experienced and PWD's experiences must be contextualized appropriately (Cencirulo et al., 2021; Grant & Zwier, 2011; Whitesel, 2017). For example, Hunt and colleagues' (2006) study reflected participants' need for counselors who were aware of and educated on both sexual orientation and disability as participants described attempts to address both issues jointly in therapy.

PWD face the implicitly biased views society espouses and are often segregated in some way from non-disabled, mainstream society (Bogart & Dunn, 2019; Charlton, 1998; Keller & Galgay, 2010; VanPuymbrouck et al., 2020). People with intellectual disabilities are educated separately, people who use assistance technology for mobility are provided entry into physical structures separately, and those facing barriers to access are regularly denied essential accommodations for social participation (Charlton, 1998; Olkin, 2017). In addition to physical barriers, PWD face legal barriers such as not being able to be legally married without losing essential federal assistance and benefits (Pulrang, 2020; 2022).

Throughout the COVID-19 pandemic, PWD were exposed to multiple threats including risk of severe infection particularly for those living in congregate settings, denial of healthcare treatment or ventilator rationing, and risking infection to maintain access to care (Lund & Ayers, 2020; Lund et al., 2020). When restrictions on masking, quarantining, isolating, and social distancing were lifted, the health and wellbeing of PWD was devalued as government leaders pushed to return to pre-COVID-19 pandemic normalcy despite ongoing risk of infection to those most vulnerable to infection (Rajkumar, 2022).

Studies have shown that while people generally report their attitudes and beliefs about PWD as positive, they hold biased views towards disabled persons (Kelly & Barnes-Holmes, 2013; Pruett & Chan, 2006; VanPuymbrouck et al., 2020). As Friedman (2019) notes, non-disabled people hold both positive and negative feelings towards disabled people, and their views on what constitutes positive treatment often conflict with PWD accounts. This contradiction is in part due to non-disabled people viewing PWD as affectionate, warm, friendly, quiet, honest, and gentile (Campbell et al., 2003; Fitchen & Amsel, 1986) which creates unfair expectations of PWD's behavior and demeanor. When PWD behave differently than what non-disabled expect, PWD are then seen negatively.

To better understand the complexities of ableism, Friedman (2019) analyzed data from 344,760 people who completed the Disability Attitude Implicit Association Test (DA-IAT) and grouped ableism along dimensions of implicit and explicit bias. Resulting groups include symbolic ableists (high in both explicit and implicit prejudice), principled conservatives (high explicit, low implicit), aversive ableists (low explicit, high implicit), and truly low prejudiced (low on both dimensions of bias; Friedman, 2019). Most respondents reported favorable views of PWD when measurements of implicit bias showed that they actually preferred non-disabled people more (low explicit, high implicit prejudice).

Studies about the microaggressive experiences of PWD shed light on pervasive and harmful behaviors directed towards disabled people. Microaggressions are verbal, behavioral, and environmental slights and cues from members of the dominant group about non-dominant group members which expresses discomfort or disapproval about marginalized group membership (Sue, 2010). Keller and Galgay (2010) conducted a focus group with 12 self-identified disabled participants and found 10 domains of microaggressions including: denial of personal identity, denial of disability experience, denial of privacy, helplessness, secondary gain, spread effect, infantilization, patronization, second-class citizen, and desexualization. Olkin and colleagues (2019) conducted a mixed method study surveying the microaggressive experiences of women with disabilities as well as conducted six focus groups. In addition to the domains Keller and Galgay (2010) found, they found 2 additional domains which included symptoms not being believed by medical professionals which delayed diagnoses as well as their disability being discounted due to appearing healthy or young. The most common microaggression experienced were people downplaying the effect disability has on your life, assumption that PWD need help, being praised for nearly anything, and denying the right to equality. The two additional domains of microaggressions identified by Olkin and colleague's (2019) study highlights how ableism may be experienced differently by women.

The experience of microaggressions has also been shown to have negative implications for PWD mental health. Kattari (2020) found that the experience of high levels of ableist microaggressions negatively correlated with positive mental health outcomes and that reports of microaggressive experiences were a concern for all participants regardless of type of disability. The research literature highlights a major conflict between how non-disabled people believe they view PWD and the actual experiences of PWD and supports the urgent need of research exploring the lived experiences of PWD.

Ableism also impacts PWD through institutional, environmental, and structural means. Structural and environmental ableism prevents PWD from entering and/or participating in spaces. Reber and colleagues (2022) explored attitudinal ableism experienced by individuals in the Flint and Detroit, Michigan area, and despite the study's focus on attitudinal ableism, participants routinely described the built environment as a way that society's attitudes about disability emerged. The quality of sidewalks for wheelchair users, decisions of store owners to not invest in accessibility features, and how governmental programs such as Medicaid and department of health and human services complicated access to necessities (ramps for their homes) impeded the way individuals were able to participate in society similarly to non-disabled individuals.

Models of Disability

Despite the development of numerous theoretical models to understand disability, literature generally embraces three different models: the moral, medical, and social models of disability (Olkin, 2002). The moral model, also called the tragedy model, is the oldest and most prevalent and typically frames disability as a result of one's actions, character, or deeds. Disability often brings with it shame and others blaming the person for their disability (Swain et al., 2003). Disability is viewed negatively and often conceptualized as an affliction. Alternatively, people may view disability as God's will and their burden to bear (Olkin, 2017).

The medical model of disability is thought to have roots in Enlightenment and views disability as abnormality in biological functioning (Olkin, 2017). The cause may be due to something going wrong, to genetics, bad habits, or one's behavior. Disability under this model is highly medicalized and individualized. The concept of abnormality is central to the medical model and is ubiquitous in psychology (Olkin, 2017).

The social model of disability stemmed from advocacy and activist movements throughout the 1970s in the United Kingdom, U.S., and Canada. The social model shifts the cause of disability from the individual to society and embraces disability as a socially constructed phenomenon (Haegele & Hodge, 2016). Disability is viewed as a normal element of human diversity, and the physically built environment and attitudes of others are considered the primary disabling factors (Olkin, 2017). Scholars view the social model as a way of deconstructing the notion of impairment as the sole cause of disability and focus for intervention, and it instead shifts efforts towards breaking down oppressive societal barriers (Charlton, 1998).

While social researchers urge the adoption of the social model (Bogart & Dunn, 2019; Olkin, 2017), some scholars point to the need to bring back the focus on the salience of impairment to PWD lives. Crow (1996) argues that breaking down social barriers and ableist attitudes will not eliminate the impact of impairment that many PWD face (e.g., chronic pain, fatigue, chronic illness). Furthermore, focusing solely on society's role in PWD lives without recognizing the subjective experience of one's body as an important component of the disability experience creates an incomplete picture of the experiences of PWD. Thus, scholars like Crow (1996) stress the importance of embracing both society's role in disability as well the individual biological element. Olkin (2017) also recognizes that there are pros and cons to all three models and that professionals working with people with disabilities need to be knowledgeable about the benefits and limitations of viewing disability from each model. Swain and colleague's (2003) explored the social model from the perspective of both counselor and client and found both to utilize a hybrid model that contained elements of both models depending on the content about disability being discussed.

Disability and Psychology

Within psychology, disability has generally been medicalized and conceptualized from a deficit-based perspective (Olkin, 1999; 2002), and literature shows that psychology training programs have been slow to incorporate disability into curriculum (Bluestone et al., 1996; Hogben & Waterman, 1997; Kemp & Mallingckrodt, 1996). Hogben & Waterman (1997) analyzed psychology texts for coverage of diversity-related issues and could not analyze disability content due to so little content being present. Even though most counselors will engage with PWD in their professional work at some point, disability has been relegated as a population that constitutes specialized training for rehabilitation clinicians (Olkin, 2002). Even in rehabilitation, a field which traditional emphasized adaption and adjustment to disability, scholars are making a push for the field to consider identity development, systemic oppression, social justice perspectives, and the importance of advocacy for people with disabilities (Bogart & Dunn, 2019; Forber-Pratt et al., 2019).

For over 20 years, scholars have been highlighting the need for psychology to view disability as a dimension of diversity as well as a group that experiences marginalization and oppression (Bogart & Dunn, 2019; Olkin, 2002; Smith et al., 2008). Ignoring this dimension of PWD’s experiences means mental health clinicians may not be considering the mental health implications of living with a disability (Kattari, 2020; Keller & Galgay, 2010). The APA asserts that disability should be conceptualized as a dimension of diversity and psychologists must be aware about how disability uniquely impacts physical, social, and emotional well-being (APA, 2017). Despite APA’s acknowledgment of disability as a multicultural issue (APA, 2017) as well as providing explicit guidelines to researchers, educators, and practicing clinicians (APA, 2022), the dearth of research on disability from a multicultural perspective suggests the field has work to do (Foley-Nicpon & Lee, 2012). Rosa and colleagues (2016) analyzed 98 highly ranked psychology undergraduate departments and found that while all programs had courses addressing psychiatric disabilities, only 20% discussed physical, intellectual, and sensory disabilities. Furthermore, course descriptions used language predominantly reflecting the medical model.

Along with psychology’s difficulty in shifting its view on disability, clinicians-in-training report being under-trained and having inconsistent contact with clients with disabilities during training which contributes to ineffective mental health treatment. Rivas and Hill (2018) conducted a phenomenological study of counselors-in-training receiving multicultural training regarding PWD. Participants reported disability being discussed separately from other social identities or only being discussed in certain courses, not across coursework. Furthermore, the way disability was approached when it was discussed gave the impression that disability as an identity was "exceptional" (Rivas & Hill, 2018, p. 122). Asking clients about a disability was conceptualized as a risk by some participants and asking was sometimes the only way to knew whether their client was disabled. Results also showed that having students with disabilities present in the class provided meaningful insight on the topic. Similarly, DeRoche and colleagues (2020) found that masters-level counselors-in-training who had both multicultural training and disability-related life experience reported high levels of self-perceived disability competence.

Parritt and O'Callaghan (2000) studied professional therapists conducting clinical work with PWD regarding relationships and sexuality issues. Unlike previously discussed studies, this study highlights the work of established professionals with PWD (lowest number of years working in this study was 8 years, highest 18+). The main theme that emerged included a tension that all therapists experienced by the "perceived otherness of the disabled client" (p. 164). Additionally, therapists reported feeling anxiety around asking about sexuality and reported evading asking about sexuality and relationships. Participants also described experiencing disability as a matter of loss, adjusting to their disabled client's physical presence, separating the disability from the person, and struggling to work with disabled clients' sexuality. Education on disability-related issues needs to be prioritized and emphasized in training so that counselors are aware when they are engaging in cross-cultural counseling. The research literature also points to the importance of prioritizing disabled students in graduate level mental health programs.

PWD and mental health treatment

Literature exploring the mental health treatment of clients with disabilities is sparse. However, the studies that have been conducted provide meaningful insights. The majority of studies exploring the client's perspective revolved around therapeutic work with clients with intellectual disabilities. Evans and Randle-Phillips (2020) conducted a meta-ethnography of the therapy experiences of people with intellectual disabilities and synthesized themes across 16 separate studies. Helpful aspects of therapy included being able to discuss struggles, confidential nature of therapy, collaboration, accommodating access needs, positive and inclusive group, positive regard and non-judgement stance of therapist, learning new skills, and positive impact therapy had on their lives. Challenging aspects of therapeutic experiences included anxiety before therapy, distress resulting from discussing challenges, inaccessibility, and maintaining growth and change. These results present important considerations for clinicians working with people with intellectual disabilities.

Previous studies that have influenced the present study include Hunt and colleagues (2006) qualitative study exploring the therapy experiences of lesbians with disabilities and Conner and colleagues (2023) study which explored the therapy experiences of adults with physical disabilities. Hunt and colleagues conducted interviews with 25 participants and constructed 9 themes. Major themes included: perceptions of their counselors regarding satisfaction or dissatisfaction, counselor effectiveness, awareness and education on issues important to lesbians as well as people with disabilities as well as awareness issues regarding their intersecting identities. Additionally, themes around bias, discrimination, and counselor identity emerged. Participants also discussed aspects of negotiating the therapy process regarding disclosing their sexual identity as well as disability identity, issues of accessibility as well as self-advocacy. The majority of participants reported being satisfied with their counseling experience and described the importance of their counselor having effective skills. Understanding and seeing their individuality within the context of their social identities emerged as well as the not approaching therapy with a “White model” (p. 167). Some participants felt as though their counselor understood their disability whereas some described having to continually educate their counselors. While only 25 participants were interviewed and the inclusion of participants who identified as lesbian were central to this study, it is important to consider how their experiences may provide guidance to counselors when working with lesbians with physical disabilities.

Conner and colleagues (2023) conducted a qualitative study looking at the psychotherapy experiences of adults with physical disabilities. 24 individuals (21 women, 3 agender individuals) were interviewed with a high proportion of LGBTQ+ participants (n =15). Four overarching domains were identified which included both (1) positive and (2) negative interactions and interventions in therapy, (3) inaccessible or accessible services, and (4) ways mental health services for people with disabilities can improve. Positive interactions and interventions included 5 themes: the progress and growth of individuals through therapy, therapist responding positively to disability-concerns, more broad positive experiences, experiences where physical and psychological symptoms were managed through treatment and self-disclosure of disability by mental health professionals. Negative interventions and interactions included avoidance of disability as a topic within therapy, invalidation of disability, inflexible or inappropriate responses by clinicians, more broad negative experiences, psychopathologizing disability, and decline in physical and psychological symptoms. The third theme included to extent to treatment was accessible for participants which included both inaccessibility and accessibility, financial constraints (high fees and poor insurance coverage), barriers to pursuing and attending therapy (e.g., difficulty locating providers and poor transportation options), and provider willingness to increase accessibility of services. Suggestions for improving therapy included the desire for mental health providers to increase disability-related knowledge, attending to accessibility needs, centering and trusting the client's disability experience, intentionally processing experiences related to being physically disabled, and attending to intersectionality. Conner and colleagues (2023) study shared overlapping themes with Hunt and colleagues (2006) including awareness of disabilities and the importance of accessibility and accommodation.

Given the dearth of literature exploring the client perspective, how is the education and training of mental health clinicians impacted? How do we know what clinicians *should* be considering when engaging in counseling with PWD if we haven't, up to this point, explored what is *actually happening* from the client's perspective? At the time of this proposed study, there has not been a qualitative inquiry into counseling experiences of people with disabilities spanning many social identities and different types of disabilities. This proposed study also has the potential to confirm overlapping and similar themes as well as distinct themes from what Hunt and colleague's (2006) and Conner and scholars (2023) found. Thus, qualitative inquiry into the therapy experiences of PWD is warranted.

CHAPTER 3

Methods and Procedures

Research Design and Paradigm

Scientific research approaches seeking knowledge and uncovering what is using qualitative methods, quantitative methods, or a mixture of the two. Each method is underpinned by different beliefs about the nature of reality and truth, how social scientists go about understanding truth, the nature of the researcher's relationship and influence on the results, and how studies are designed, and information is collected. Quantitative research asks *why* and focuses on how numbers explain the cause of a particular phenomenon or relationship between phenomena, with the assumption that one singular generalizable truth or reality regarding these phenomena exists. Qualitative research asks *how* or *what* about a particular phenomenon and focuses on words, stories, and meaning while acknowledging that multiple realities may surface as a result.

Qualitative inquiry complements counseling psychology research well given the opportunities it provides to explore in-depth variables that are otherwise difficult to identify (Morrow, 2007). Not only does it provide room for exploration of phenomenon that have been largely unexplored, but it also often mirrors the narrative nature of therapeutic work (Morrow, 2007). Given the documented dearth of literature on the therapeutic experiences of people with disabilities and chronic illnesses presented in chapter two, a qualitative approach to inquiry allows for in-depth exploration and meaning-making of this phenomenon.

Qualitative research is supported by several research paradigms or set of beliefs that guide what researchers think about the nature of truth. Social constructivism, one such paradigm, states that there are “as many realities as there are participants” (Morrow, 2007, p. 213) and that these realities depend on the connection between self and world (Hayes & Singh, 2012). The researcher’s values and subjectivity are an important aspect of the research, and the interaction of researcher and participant are central to knowledge construction (Hayes & Singh, 2012). Research findings are shared in narrative form, are largely written from the participants’ perspective, and reflect the role of the researcher and the research setting in understanding the phenomenon.

Phenomenology can be viewed both through a philosophical as well as methodological lens. The philosophical roots of phenomenology research rely heavily on the work of German mathematician Edmund Husserl. Central to Husserl’s view on phenomenology is the idea that individuals create meaning through interacting with the surrounding world. He labeled these dynamic interactions essences, which unfold at “the intersections of experience and meaning-making” (Freeman, 2021, p.276).

Method

Participant criteria and Recruitment

Eligible participants for this study included individuals who were 18 years of age or older, identified as a person living with a disability or ‘disabled’, and had attended at least one, 50-minute counseling/psychotherapy session. Due to the nature of the participants required for this study, purposive criterion sampling was used for this study to allow the researcher to make judgments about each potential participant’s ability to provide information (Creswell & Creswell, 2007). Electronic recruitment flyers were circulated on social media platforms (e.g., Instagram, X, and Facebook), and the primary researcher used personal and professional networks (e.g., support groups for people with disabilities, professional listservs) to connect with potential participants. The primary researcher also contacted counseling clinics to request permission for electronic recruitment flyers to be disseminated. The primary researcher aimed to recruit no less than 5 and no more than 10 participants for this study to maintain study feasibility (Polkinghorne, 1989).

Procedure

Those interested in participating in the study were directed to complete a screener survey where they provided information regarding their general experiences in psychotherapy, the duration of their experiences, and their comfort level discussing their experiences with the primary researcher who identified herself as a disabled psychologist in training. Once complete, the primary researcher reviewed submissions and contacted all eligible participants. The primary researcher reviewed a total of 10 submissions and invited 9 eligible participants to provide informed consent and demographic information through an online questionnaire. 1 individual provided contact information through the screener questionnaire but left the remaining fields blank. The researcher made several contact attempts to elicit additional information for determining suitable for the study but was unsuccessful. The primary researcher contacted each eligible participant by email to schedule their interview once consent was provided and demographic information was complete. Nine individuals consented to participate and provided demographic information. Seven individuals followed through and scheduled an interview, and two individuals did not respond to the primary researcher's attempts to schedule interviews. Participant recruitment ceased after the first 7 interviews were completed.

Semi-structured, phenomenological interviews were conducted to provide each participant with ample opportunity to describe their experiences in counseling as well as allow the researcher the opportunity to ask probing and clarifying questions. The primary researcher conducted all the interviews. Bevan (2014) developed 3 domains for phenomenological interviews which include contextualization, apprehending the phenomena, and clarifying the phenomena (p. 139). To explore the context of participants' experiences, questions regarding the participant's disability, general experiences pursuing psychotherapy treatment, reasons for seeking services, and number and duration of different counseling experiences were asked. Structured questions were asked to ascertain the meaning behind participants' interpretive questions and to explore participants' experience in greater detail. Imaginative variation, a technique typically applied during data analysis, allows the researcher to explore the phenomena under study by "imaginatively varying its structural components to uncover invariant parts (Bevan, 2014, p. 141). However, some scholars (Bevan, 2014; Turley et al., 2016) have encouraged researchers to integrate imaginative variation into the interview itself allowing the phenomena to be actively explored, for modes of appearance to be more substantially examined, and to keep the imaginative variation grounded in the context of the participant's experience. For this study, imaginative variation was incorporated into interviews conducted later in the data collection process to further examine participant's experiences regarding the social identities of their therapists.

Prior to the interview, participants were asked about accommodation needed to make the interview accessible. One participant requested a Zoom or phone interview due to being homebound. All participants were offered the option of either an in-person or remote interview. Six participants chose remote interviews due to geographical location, and one participant requested a remote interview for accessibility purposes. All interviews were conducted using video conferencing software and were audio and video recorded with the participants knowledge and consent.

At the beginning of each interview, participants were provided with a description of the study and information regarding privacy and confidentiality was reviewed. Due to the sensitive nature of content that may be discussed, participants were reminded that they had the option to skip questions at any time as well as end the interview should they want to though no participants chose to skip questions or prematurely end the interview. Participants were also given the opportunity choose a pseudonym for reference in the transcript and results write-up. Four participants chose their pseudonym and three declined.

Study Instruments

The study instruments used in this study included the primary researcher, a brief demographic questionnaire, and a semi-structured interview protocol. The questionnaire asked participants to provide information regarding the nature of disability (onset and category of disability), their age, race, ethnicity or ethnic culture, gender identity, and sexual orientation.

Each participant completed one semi-structured interview with the primary researcher. Interview lengths ranged from 31 minutes to 89 minutes (mean = 57 minutes). Interviews comprised of open-ended questions that focused on the lived experiences of people with disabilities receiving counseling services (Vagle, 2018). Interview questions were developed based on the extant literature addressing the experiences of people with disabilities in individual settings. Questions explored their specific disability or disabilities, frequency, and duration of their psychotherapy experiences, and how they experienced counseling as well as ways in which disability-specific considerations may or may not have been incorporated into counseling treatment. Each interview was audio and video recorded using an a videotelephony software program which produced transcription text documents. The primary researcher then converted all interview transcriptions to Microsoft Word (2016) and reviewed and revised each transcript for accuracy.

Data Analysis

Since their initial 2006 article, Braun and Clarke have made considerable efforts in clarifying how thematic analysis (TA) is a broad term that includes several different styles of TA that reflect varying philosophical and methodological approaches to research and data analysis (Braun & Clarke, 2019; Braun et al., 2019; Braun, Clarke, & Weate, 2017). The three schools – coding reliability, codebook, and reflexive thematic analysis – all collect qualitative data with the goal of developing themes though vary in the conceptualization of themes and approach to data analysis (Braun et al., 2019). Coding reliability emphasizes reliability and replication in data analysis and themes are conceptualized as domains which stem directly from the research questions (Braun et al., 2019). A predetermined list of codes and themes are used to guide analysis with multiple independent coders aiming for a certain level of consensus. Codebook TA (Braun et al., 2019) uses a similar structured approach to data analysis like coding reliability however without the use of reliability measures like Cohen’s kappa. Similar to coding reliability TA, codebook TA conceptualizes themes as domains and themes are typically determined in advance of analysis.

There are several forms of reflexive TA (e.g., Braun & Clark, 2006; Langdridge, 2004), and this study utilized Braun and Clarke’s 2006 framework with noted conceptualization revisions reflected in updated scholarship (e.g., Braun, 2022; Braun & Clarke, 2019; Braun et al., 2019; Braun, Clarke, & Weate, 2017). The goal of reflexive thematic analysis (RTA) (Braun et al., 2019;) is “developing, analyzing, and interpreting patterns across a qualitative data set” (Braun, 2022, p.4). Additionally, Braun (2022) outlines four dimensions of RTA and has further emphasized the importance of transparency regarding the researcher’s orientation to the data to ensure appropriateness of study design with RTA. For this study, a constructionist theoretical framework guides the meaning of reality or “truth” in that there is no objective reality to be ascertained from the data. Rather, the data stemming from this study reflects the connection between each participant and their world (Hayes & Singh, 2012). Additionally, this study adopted an experiential framework in that the lived experiences and perspectives of each participant was centered (Braun, 2022). Finally, the focus of meaning for this study occurred semantically with coding focused on surface level patterns and themes.

In Reflexive Thematic Analysis (RTA), the researcher is an active participant in producing knowledge, and the researcher’s subjectivity is considered an asset and strength (Braun et al, 2018; Braun & Clarke, 2019). Given the researcher’s active engagement in generating knowledge, themes are not found in the data but produced from the data with the goal of telling a story (Braun & Clarke, 2019). Throughout data collection and analysis, the researcher assumes an orientation to the data and analysis from a stance of reflexivity and thoughtfulness (Braun & Clarke, 2019). Multiple researchers were involved in this study to engage in a “collaborative and reflexive” (Braun & Clarke, p. 584) data analysis process with the goal of producing richer meaning in place of a consensus.

Data saturation is a widely used approach to guide sample size and data collection in thematic analysis (Tong & Craig, 2019). However, several scholars question its usefulness both within qualitative research broadly as well as within RTA (Braun & Clarke, 2019b; Braun et al., 2019). Braun and colleagues (2019) highlight that the philosophical nature of qualitative research emphasizes “the partial, multiple, and contextual nature of meaning, and view of knowledge as the actively *created* product” of a researcher (p. 851). They emphasize that data saturation, especially as a rationale for sample size, may be more appropriate for coding-reliability TA. Furthermore, Braun and colleagues (2019) acknowledge that for RTA there are “*no magic formulas*” (p.851) for determining sample size though suggest a minimum of five or six interviews for a very small project like an unpublished dissertation

Six Phases of Data Analysis

Phase 1 of data analysis required the researcher to familiarize themselves with and immerse themselves in the data. For this study, the primary researcher transcribed all data to maintain participant privacy and confidentiality. The primary researcher checked each transcript for accuracy and conducted re-readings of each transcript several times. To enrich the data analysis process, the primary researcher recruited two additional researchers including a graduate student, and an undergraduate student familiar with mental health treatment, disability, and psychological research. Prior to initial readings of transcripts, the research team met collectively to discuss principles of qualitative research, phenomenology, and reflexive thematic analysis (Braun & Clarke, 2006, 2019). The primary researcher engaged the team in reflection about their understandings, experiences, and orientations to the phenomenon of inquiry.

Phase two of data analysis involved generating initial codes. In RTA, codes are considered the “building blocks” (Bryne, 2021, p.1399) of what will later evolve into themes. Inductive coding was utilized, and each team member was encouraged to code any data item that focused on the research question and identify each code with a brief label. The comment feature in Microsoft Word was utilized to identify codes for each transcript. Throughout data analysis the primary researcher met with the research team first on a weekly basis and then twice weekly to discuss patterned responses and codes. Semantic codes were generated when meaningful data was identified. Examples of initial codes are provided in table 1 below.

Table 1

Initial Coding Examples

Data extract	*Initial Code Label*
I think at the time I was starting to apply to graduate schools. So, there was like stress there, and I think she just associated stress with my neurodivergency. It was just, it was just normal stress.	Misattribution of stress to disability
What I like about my therapist now is that she gets it because she lives it, and I can be as weird as I want.	Importance of therapist shared identity

Braun and colleagues (2019) highlight that codes often evolve throughout the coding process such that they may be broken down into separate codes, relabeled, or subsumed with other codes to better reflect a developing conceptualization of the data. The researchers coded each transcript independently and team meetings were held, not to reach consensus about codes, but to collaboratively discuss the codes to provide more nuance to the meaning of the data (Braun & Clarke, 2019). The research team met a total of 9 times across 7 weeks to discuss codes and add greater depth to the analysis process. Considerable time was spent discussing each researcher’s impression of the data and the patterns of meaning identified throughout the coding process. Upon conclusion of team research meetings, the primary researcher placed all codes in a Microsoft Excel (2016) spreadsheet. The primary researcher then reviewed all codes and tracked the evolution of codes in the spreadsheet which provided a place to return to when a particular coding approach was no longer appropriate. An example of the evolution of codes is provided in table 2.

Table 2

Iterations of Codes

Data extract	*Iteration 2*	*Iteration 3*
Is my reaction and my reason for being upset "valid (participant motions air quotes) for a normal person?" Or am I being a little bit whack-a-doodle? And let's check this and see where I'm at.	Disability & Other MH Symptoms	Validation of experience
You know when you're in a rehab. And you know, I'm not talking substance abuse, I'm talking about what looks like and feels like a hospital setting. I had a roommate, you know, like how am I having Zooms for therapy? I had to find another space. And when I was in my room and didn't have a … Is someone going to come in? And, you know, it's just … the wall is up.	Navigating Environment	Burden of mismatch between needs and environment

Once codes were developed, the next phase involved generating initial themes. In their seminal article, Braun and Clarke (2006) identified the third step in the data analysis process as "searching for themes" (p. 89). However, to appropriately acknowledge the intersection of researcher subjectivity, the data itself, and the data analysis process, Braun and Clarke later clarified that themes do not "passively emerge" from the data as if they are "waiting to be identified and retrieved" (2019, p. 594). Rather, terms like developing (Braun, Clarke, & Weate, 2016), constructing (Braun et al., 2018), or generating' (Braun & Clarke, 2019) are recommended to capture the active role the researcher assumes in the generation of themes. RTA differs from other schools of TA in that the goal of data analysis is not to "accurately summarize the data" or reach a consensus but to develop a "coherent and compelling *interpretation* of the data, grounded in the data (Braun et al., 2019, pg. 848). The role of the researcher is to adopt an orientation characterized by "reflective and thoughtful engagement with their data" along with "reflexive and thoughtful engagement" with the analytic process (Braun & Clarke, 2019, p. 594).

In this stage, the researcher shifted the focus from individual data items to identifying meaning across the dataset. To accomplish this, the primary researcher placed similar codes next to one another in the spreadsheet and spent considerable time reflecting on how codes related to one another. Once relationships were identified, initial themes were constructed, the primary researcher utilized thematic mapping to visualize the candidate themes.

Phase four involved a recursive review of both the candidate themes in relation to the coded extracts as well as reviewing meaning across the entire data set. Review occurred across two levels. Level 1 involved reviewing the relationships amongst the data items and codes that contributed to each theme. Level 2 involved reviewing the candidate themes against the entire data set. Bryne (2021) highlights that it is not atypical for candidate themes to be removed or reworked at this stage. Similarly, coded data extracts may also be incongruent and need to undergo revision at this stage. Themes are evaluated as to "how well they provide the most apt interpretation of the data in relation to the research question(s)" (Byrne, 2021, pp.1404-1405).

Table 3

Candidate Themes and Sub-Themes

Candidate Theme	*Subthemes*
Factors promoting an engaged and dynamic experience	Flexible inclusion of disability; collaboration; shared salient identities; accessible and accommodating environment
Factors impeding engagement and development	Attitudinal, environmental, non-shared salient identities

The lines between phases four and five of data analysis can be blurry given the recursive and iterative nature of RTA. After a considerable, in-depth review of the initial candidate themes, the primary researcher reconceptualized the broader themes and subthemes. The final themes and definitions are detailed in the results section of this report. *Phase 6* involved the production of the report.

Researchers' Positionalities

Central to qualitative research is the researchers' acknowledgment of their unique position as it relates to the phenomena being studied. The following describes the primary researcher's positions regarding (a) people with disabilities, both personally and professionally, (b) mental health treatment with people with disabilities, and (c) disability-specific considerations for mental health treatment.

Subjectivity statement – Primary Researcher

I am a White, 37-year-old, cisgender woman who is hard of hearing. I am also a Counseling Psychology doctoral candidate at the University of Georgia. Disabilities and chronic illnesses have been a part of my nuclear and extended family's life since I was young. Both my paternal grandfather and father had significant hearing loss from an early age, and I have two siblings who live with chronic illnesses and mental health conditions. Notably, the term disability was never used to label or describe these experiences in my family. The focus of conversations generally revolved around treatment, achieving a sense of normalcy, and blending in with society as much as possible.

From a young age, I have been hard of hearing. Early childhood screenings indicated that hearing loss was present, and given my genetics, all signs pointed to my hearing loss worsening as I got older. I struggled to hear in educational and social settings throughout my teens and twenties, and I downplayed the impact of my hearing both to myself and others in attempts to blend in and appear normal. I would laugh off miscommunications that occurred in social settings and often pretended to hear what was being said in conversation to avoid disclosing my difficulties. It wasn’t until I began my studies for my master’s degree that I realized how much my hard of hearing was impacting my experiences, regardless of my ability to accept it. A class exercise exploring privilege, power, and oppression left me realizing that my hard of hearing constituted a disability, a thought I had never considered until that point in time. It was at this time I unearthed a completely unexplored aspect of myself. This discovery prompted me to focus class projects, research papers, presentations, and guest lectures on various aspects of disability. I pursued audiological evaluations, registered with the Disability Resource Office at my university, and after a four-year journey, was able to acquire hearing aids.

Since my initial realization, I began exploring what it meant to openly discuss my hard of hearing within social settings and slowly began to process my internalized ableism. Processing the invisible nature of my disability and how my other identities influence my experiences is an ongoing journey. The onset of the COVID-19 pandemic increased the salience of my hard of hearing given the almost ubiquitous use of masks and the resulting inability to rely on speechreading for communication. It also provided a first-hand experience of how environmental changes can be disabling and suddenly change how one’s disability operates. On the other hand, the increase in use of video conferencing software like Zoom made attending classes, research meetings, and general educational activities accessible as others were generally unmasked due to being physically separated. Still, challenges with the extremely slow integration of closed captioning made learning challenging. For example, early in the COVID-19 pandemic I had a statistics professor record all his lectures so that students could refer to lecture material when working on independent assignments. However, because of my approved course accommodations for all lecture recordings to be captioned, he decided against post the recordings on the online classroom forum as that would require him to take the time to caption each recording. As such, he communicated to the class that recordings would be provided upon email request to maneuver around my established accommodations. It’s instances like this one where, even when institutions have procedures in place to minimize environmental barriers to participation, the attitudes and behaviors of others can prevent access.

I am both a psychologist-in-training and have also received counseling services from three separate mental health clinicians. Thus, I have personal and professional experiences from both sides of the therapeutic couch, and I am deeply invested in how mental health clinicians are educated and trained to work with people with disabilities. From the client perspective, I have experienced therapists neglecting to inquire about any health conditions and disabilities that may impact my experiences and specifically my mental health. I was further along in my disability identity development by the time I started seeing my second therapist, and thus, I broached the topic myself. While this therapist was open to me exploring my hard of hearing, I struggled in feeling as though she understood how my disability impacted me on a fundamental level.

One of my goals with my second therapist was to explore and process difficulties in social situations and pervasive loneliness that I was experiencing. My loneliness coincided with increased social withdrawal and feelings of depression. Being hard of hearing in a hearing world is inherently lonely. I often missed key context in conversations and resorted to nodding along and laughing when others speak so as to give the appearance of understanding what is being said. With my second therapist I called it *the great pretend*, and as a naturally extroverted, social person, the great pretend is hell. I find immense joy in connecting with others on an authentic level, and my hard of hearing directly conflicts with this goal.

I struggled in discussing the great pretend with my second therapist, and I never truly felt that they understood the emotional distress it caused. This therapist would often transition towards offering solutions and advice before confirming that she understood and conveyed her understanding of how my experiences were uniquely related to my hearing. Furthermore, this therapist neglected to explore the feelings that often stem from having disability-related needs. For example, I remember a specific instance where I was tearfully discussing a friendship that I was struggling with. This friend mumbled when talking to me, and I would often pretend that I was understanding what they were saying when I typically was quite lost. I tried to convey how these experiences in social settings were not uncommon and that I often left them feeling terribly lonely. I recall my therapist responding with, “why don’t you simply ask them to repeat themselves?” This response left me feeling even more lonely as there was a lack of understanding about the experiences of disabled people disclosing their needs and a lack of exploration into my experiences disclosing my hearing status to others.

Disclosing one’s disability status is a complicated experience and one that can have both positive and negative consequences. Coupled with the loneliness I was experiencing due to graduate school; I knew that my mental health was in a fragile and rapidly declining state. Looking back on this experience, I would have greatly benefited from my therapist having some foundational knowledge about disability-related issues as it would’ve helped me contextualize my distress. From an outsider’s perspective, my symptoms resembled depression. From my perspective, I knew that my symptoms of increased social withdrawal, negative thoughts about self, suicidal ideation, and depressed mood were inextricably intertwined with my disability.

Clearly, my hard of hearing directly impacts how I navigate social spaces and develop interpersonal relationships, and my second therapist lacked the ability to understand how connected my hard of hearing was to my mental health concerns. I terminated early with that therapist for a variety of reasons, one of them being that I felt that she lacked the ability to help me adequately navigate how my disability intertwined with my mental health challenges and interpersonal difficulties. These experiences left me feeling discouraged about the ability of therapists to help me process my own feelings about my disability as well as explore how it intertwined with my interpersonal relationships. These experiences also left me feeling isolated in my experiences, an experience not uncommon to people with disabilities.

In addition to my own therapy experiences, I have been privy to other disabled people sharing their own therapy experiences. Online spaces and social media platforms have increasingly provided meaningful ways for the disability community to connect and bond over shared experiences. A simple search on Twitter will result in a variety of discussions threads where people discuss their difficulties in finding therapists who have a basic understanding of disability-related issues and how these issues coincide with mental health difficulties. Furthermore, people who have attempted to discuss their disabilities in therapy (e.g., mobility aid users, people living with chronic pain) have described the harm they have experienced when therapists use ineffective or inappropriate interventions or attempt to treat their presenting concerns from theoretical orientations that feel incompatible with how they understand their disability. I have also been privy to other individuals' positive experiences navigating disability issues in therapy and recognizing how appreciative they were of their therapist's ability to help them process their experiences.

Engaging in professional work that heavily relies on understanding verbal communication has exponentially increased the salience of my hearing loss in day-to-day life. Given my reliance on adjusting my hearing aid levels with my mobile device, I have had to disclose my disability status with clients from the outset of engaging in services should adjustment be needed. Thus, environmental and relational aspects have increased the visibility of my disability.

Professionally, I have worked with a diverse group of clients across ethnic and racial identities, linguistic diversity, types of disability, and across the lifespan. For two years I provided clinical care to adolescents and young adults living with Type 1 and Type 2 diabetes. Most of the clients I worked with were Black and Latinx individuals, and through working with them, my understanding of intersectionality expanded. I worked with kids who not only experienced shame about their diabetes but were experienced racism in the classrooms and in doctor's offices. Families were an integral part of my work, and my knowledge and skill in incorporating family and cultural values into clinical also grew. My knowledge of myself as a cultural individual also grew. I contended with my own biases and lack of knowledge regarding many of my client's backgrounds. Importantly, I was reminded not to focus on the lack of knowledge but to prioritize filling the gaps in knowledge to provide better care.

I am privileged to collaborate with a small but mighty army of mental health clinicians who are challenging the need for disability-affirmative and disability justice-oriented mental health treatment. I am a member of the IDEAL research lab at the University of Georgia advised by Dr. Collette Chapman-Hilliard which focuses scholarly efforts on addressing the lack of literature exploring the intersection of disability, people with disabilities, and psychology. As a team, we have experienced the frustration in getting professional organizations to recognize the legitimacy of addressing training, education, and literature gaps in focusing on persons with disabilities. For the last four years, I have had the privilege of witnessing the experiences and frustrations of others, and coupled with my own experiences, I have longed to contribute to the paucity of literature addressing the intersection of mental health treatment and disability.

Subjectivity statement – Research Team Member #1

I am a 38-year-old, White, cisgender female who identifies as nondisabled. I am currently enrolled as a graduate student at the University of Georgia. Disability has significantly shaped my personal experience to the extent that I was raised by disabled parents. Professionally, I have dedicated approximately fourteen years to direct service in addressing the academic, behavioral, emotional, psychological, and social needs of persons with disabilities.

Growing up, my father, who has since passed away, was diagnosed as having multiple mood and substance use disorders, which later contributed to an acquired physical disability. The presence of disability in my father's life prompted many challenges for our family (e.g., insecurity in obtaining basic needs, emotional implications, social consequences). Although my father struggled with mental health concerns for decades, it was not until he acquired a physical disability, post-stroke, that his condition was described as such. My early childhood and adolescent years involved multiple periods of separation from my father due his extensive mental healthcare needs. Throughout his lifetime, my father engaged in a wide range of treatments, including, but not limited to psychotherapy, electroconvulsive therapy, pharmacological therapy, and a range of medical interventions.

Under very different circumstances, disability also impacted my relationship with my mother. Diagnosed as having Chiari 1 and syringomyelia, my mother required brain surgery to prevent otherwise inevitable paralysis while I was enrolled as an undergraduate student. This experience resulted in increased within-home responsibilities, the need to maintain multiple sources of income, and necessitated that I serve as a caregiver for both of my parents, as well as my younger brother throughout my mother's recovery. At present, my mother is identified as having a disability in that she functions with a spinal cord injury and receives ongoing treatment through a chronic pain management clinic. Each of the children in our family has been identified as having the brain malformation experienced by my mother, though the only one of us to experience a resulting disability is my younger brother, as his condition required brain surgery, as well, though his disability was temporary and has since been resolved.

Professionally, I have experience serving persons with disabilities in the context of both k-12 educational spaces and clinical mental health counseling. For 12 years I served as Interrelated Special Education Teacher across five school sites, including three elementary schools and two middle schools. While working in this capacity, I collaborated with colleagues to meet the unique needs of students eligible to receive special education services.

I am also a mental health counselor-in training, and my clinical commitment involves collaborating with an interdisciplinary team to provide direct mental health services for individuals of all ages, many of whom are identified as having a disability. I also have had the opportunity to co- lead a small support group for older adults with disabilities. Serving as a clinician for persons with disability, I have gained insight regarding nuances in individuals' lived experiences as they have opened up about positive and negative experiences associated with their disability statuses.

I have engaged in social justice coursework and additional professional training regarding persons with disability. I am excited to assist with this project so that I may contribute to addressing mental health inequities and support literature surrounding the psychotherapy experiences of persons with disability.

Subjectivity statement – Research Team Member #2

Being an able-bodied, cisgender, Indian woman has immensely impacted the way I navigate my emerging adulthood. I am currently an undergraduate student at the University of Georgia with a double major in Psychology B.S and Women Studies B.A. with a minor in Human Services. Consequently, I enjoy utilizing knowledge from my majors to decode various aspects of my identity.

While I do not have any diagnosed disabilities, I have seen a snippet of what it looked like through my grandfather. In 2006, my grandfather was diagnosed with laryngeal cancer and shortly had to have a laryngectomy. As a result of the surgery, he lost his larynx (also known as the voice box) and was never going to be able to speak normally again. He always had to carry around an electrolarynx, which was a small tube-like device that could be placed against one’s neck to create a voice-like sound. I had never seen anyone else have the condition that he did, and it left a significant impression on me. Witnessing my grandfather's struggles with communication and the way society often treated him differently made me acutely aware of the struggles that people with disabilities had. He would often face infantilization once others noticed his use of the electrolarynx. These situations caused both me and him significant frustration because they contradicted his obvious intelligence and served as a marker to the beginning of my interest in studying the impacts of social attitudes towards individuals with a disability.

Vicariously living through my grandfather's disability was only the surface of my piqued curiosity on the experiences of individuals with a disability. As I moved into my upper-level academic courses, I started to notice more intersections of disabilities and socioeconomic conversations. I remember sitting in my women studies classes and being fascinated by this one paper called *A Qualitative Exploration of the Female Experience of Autism Spectrum Disorder*. It felt like I got a completely new perspective that was so different from my understanding of a "default" human experience. Reading this article, especially through the lens of gender, made me question how "normality" was viewed within society and how detrimental this idea was for individuals who do not meet the description for having "normal" human experiences. A similar theme was discovered when I took a human development and mental health class that broke down the various models of disabilities and its implications for disabled individuals. It made me realize how flawed the portrayal of disabilities is by the medical model as it regards them as individuals who need to be fixed rather than socially accommodated to. Engaging with case studies of individuals with invisible disabilities also opened my eyes to blatant ableism that I had never even known existed before. Having learned the struggles in navigating both developmental and acquired disabilities has encouraged me to pursue a career that helps support people with disabilities. As a future helping professional, I aim to advocate for environments that are inclusive and accessible, so individuals with disabilities can navigate comfortably without needing special accommodations.

From my perspective, "normalcy" seems to function as a set of arbitrary criteria constructed by society to place people within the binary — a sentiment that I do not agree with.

Rather than fixing people with disabilities, I believe that society as a whole needs to change their own views about what a “normal” human experience looks like. Adopting a social model of disability approach can better prevent people with disabilities from feeling isolated from neurotypical or able-bodied people. Through research and counseling education, I aspire to create a safe environment for people who feel like they don’t fit the “normalcy criteria” and advocate for better accommodations to their disabilities. I am grateful that I am able to learn about disability studies within my majors, and I hope that I can learn enough to better support women with disabilities as a Women’s Wellness Counselor/Therapist.

CHAPTER 4

Results

The following chapter presents the results from individual interviews with 7 participants ranging in age 25-48 (see Table 4 – Participant Demographics). Six of the participants identified as female and one identified as genderqueer. The category of disabilities of the participants included neurodivergent (n = 3), chronic illness (n = 3), psychological/emotional (n = 3), mobility/physical (n = 2), acquired brain injury (n = 2), spinal cord injury (n = 1), and traumatic brain injury (n = 1). Participants were able to select all categories that best described their disabilities with several participants selecting more than one. Two participants identified as living with multiple disabilities. Five participants categorized their disability as chronic with two identifying as both acute and chronic, reflecting multiple disabilities. Most participants were White (n=4) with the three remaining participants identifying as Ashkenazi, Black, and Latino (a)/Hispanic (White).

Table 4

Participant Demographics

Pseudonym	*Age*	*Gender*	*Race*	*Ethnicity*
Nova	30	Genderqueer	White	English, Scottish, Irish, German
Cat	48	Female	Ashkenazi	Jewish
Sandie	29	Female	Black	Black/African American descent
Clara	42	Female	White	Eastern European Jewish

Anne	45	Female	White	European
Beth	33	Female	White	American or Eastern European
Eva	25	Female	White	Latina / Mexican

Table 5

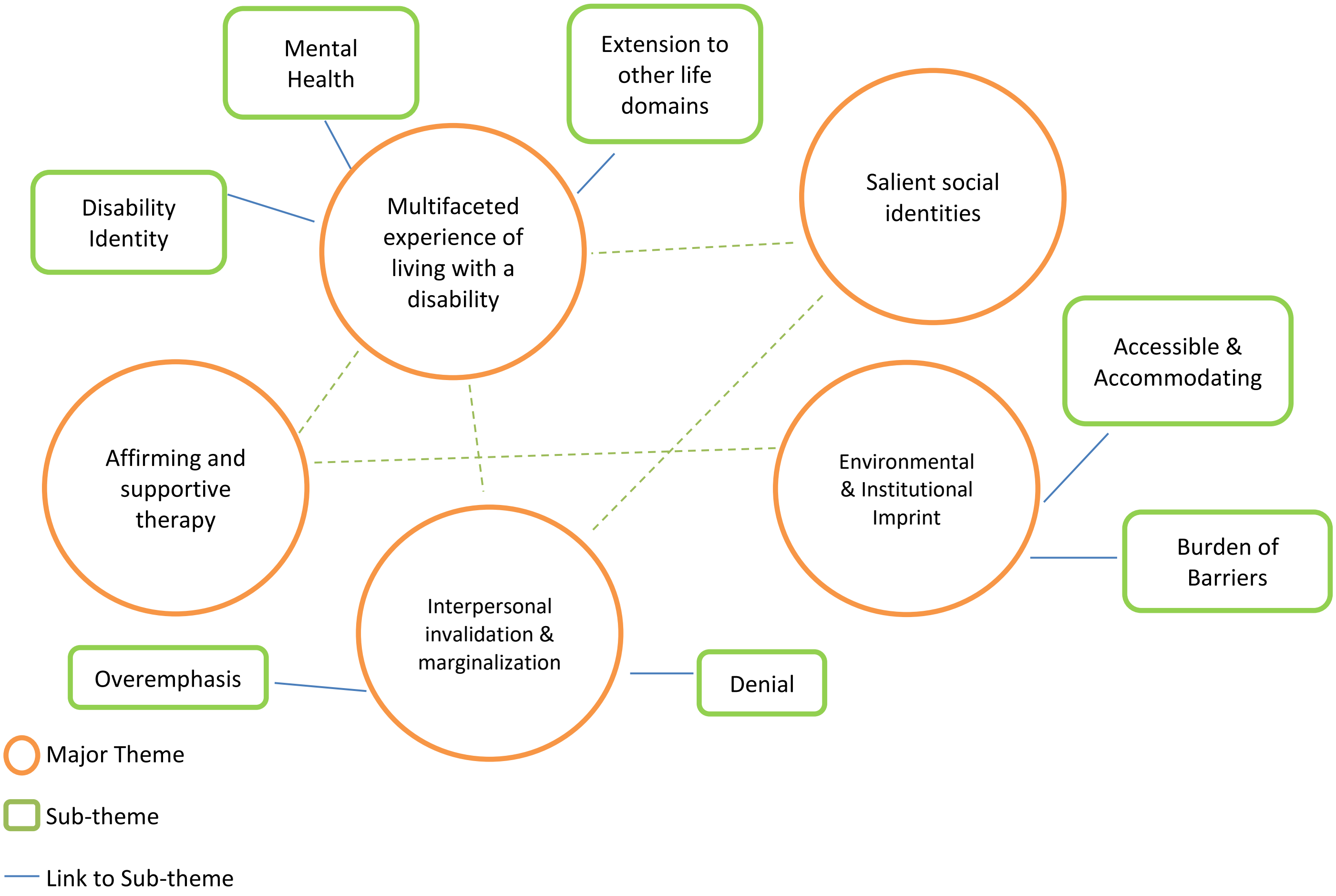
Disability Characteristics of Participants

Pseudonym	*Disability Category*	*Multiple Disabilities*	*Onset*	*Nature of Disability*
Nova	Neurodivergent	No	Developmental	Chronic
Cat	Psychological/Emotional; Neurodivergent	No	Developmental	Chronic
Sandie	Chronic Illness	No	Acquired	Chronic
Clara	Mobility/Physical; Acquired Brain Injury; Psychological Emotional, Chronic Illness	Yes	Acquired	Acute, Chronic
Anne	Mobility/Physical, Spinal Cord (SCI)	No	Acquired	Chronic
Beth	Acquired Brain Injury, Other Disability Category – Traumatic Brain Injury	No	Acquired	Chronic
Eva	Psychological/Emotional, Chronic Illness, Neurodivergent	Yes	Developmental, Acquired	Acute, Chronic

Reflexive thematic analysis (Braun & Clarke, 2006; Braun et al., 2019) was utilized to identify patterns and construct broad themes that capture the meaningfulness of psychotherapy experiences of the participants interviewed. Inductive coding was used in that data was open-coded. No pre-determined codes were utilized to understand the data. Data was coded at a semantic level which allowed the researcher to progress from "*description*, where the data have simply been organized to show patterns in semantic content and summarized, to *interpretation*, where there is an attempt to theorize the significance of the patterns and their broader meanings" (italics in original) (Braun & Clarke, 2006, pg.84). There were five major themes which informed the psychotherapy experiences of the participants – (a) multifaceted experience of living with a disability, (b) affirming and supportive therapy, (c) interpersonal invalidation and marginalization, (d) salient social identities, and (e) environmental and institutional imprint (see Figure 1).

Figure 1

Relationship Between Themes



Relationships Between Themes

Relationship between the 5 themes

Living with a disability is a multi-faceted experience characterized by disability identity, impact of disability on others, and related mental health realities. Disability identity looked different depending on the nature and salience of the disability in participants lives and emerged in psychotherapy in a similar fashion. Navigating different aspects of disability identity was a common reality and psychotherapy was well-situated to address this need when the therapist was intentional about creating an accommodating, supportive, and affirming therapeutic experience. Disabled individuals often experienced mental health challenges, either related to or separate from their disability, and the therapist's awareness of this created the opportunity to target these mental health challenges with appropriate interventions. Living with a disability not only impacted the participants' lives but also extended to other people. A flexible and supportive therapeutic treatment approach provided a space to address the many ways disability impacted others.

While many psychotherapists offered supportive and affirming care for disabled clients, they were not immune to the social, institutional, and environmental realities of working with clients from a marginalized group. Unchecked biases led to clinicians reducing participants down to their disability, ignoring the salience of their disability, and decentering their desires and input. Many of these experiences created a disconnect between clients and their clinicians. The institutional and physical environments where therapy took place along with the surrounding environment either increased accessibility to participating in therapy or presented unique challenges to engaging in treatment. A match between a person's needs and environment reduced barriers to psychotherapy, and the therapist often played a role in eliminating these barriers, whether intentionally or unintentionally. However, mismatches between the individuals' needs and the environment created additional challenges when engaging in psychotherapy, often coming at the physical and emotional expense of the participants. Participants demonstrated increasing resolve in the face of barriers and often persisted with treatment, making the best of bad situations. Disability uniquely intersects with other social identities (e.g., gender, race, ethnicity), and individuals who shared salient, social identities with their therapists felt increasingly understood and validated in their experiences. Furthermore, the low prevalence of ethnic and racial diversity of providers within the mental health field was salient for several participants and added complexity to their psychotherapy experiences.

Theme 1: Living with a disability is a multifaceted experience

Participants discussed how being disabled is not a one-size-fits-all phenomenon, and the way the disability experience appeared within the psychotherapy context varied with the individual's relationship to their disability identity, the presence of mental health along with their disability, and the way disability spread to other areas of their lives. Living with a disability was just one aspect of the individuals' lives and varied in its salience. The following section will explore the different facets of living with a disability within the context of psychotherapy.

Identity

Participants described various experiences where they explored both their disability identity as well as their varying relationship to it within the context of therapy. Participants addressed their conflicting feelings about identifying as disabled, making sense of multiple disabilities, and recognizing disability as one aspect of themselves. Many participants also noted the varying roles each therapist had in exploring their disability identity. One participant, Nova (who used all pronouns) described a therapy session where they shared with their therapist their struggles of discussing openly with their peers how their neurodivergent identity positively impacted them. They shared:

> So, when I'm being really hard on myself. And I'm like, I can't, I can't talk about this stuff to my friends. I can't tell my friends this stuff. She’s like … it is very existential … she's like, why can't you do that? And I'm like, well, if I tell them they're gonna think this about me. Well, why would they think that about you? And then it's just like going down that rabbit hole. And then we got to a really strong point, which I didn't feel was deep inside of me until I said it out loud. And I was like, well I'm just not normal! And she was like, talk about normal because you've told me you hate using that word in therapy. Because I hate using that word in the therapy space. She's like, talk about normal. So like, I got to explore that. Like what I really thought about the word normal, which I don't think anybody is normal, but I think normal is a comfortable mask to put on.

Nova further noted how their therapist’s skills facilitated their exploration of normalcy and feelings in relation to their neurodivergence. They shared:

> So, yeah. It's her ability to question the discomfort, which I feel like soapbox here, like I don't understand. I don't think a lot of therapists like to question discomfort. I think it's uncomfortable for the therapist so then it just doesn't happen, but that is where so much happens.

Nova’s comments reflect how therapy was a helpful space to explore their own views on disability and their perspective of normalcy, a common sentiment people in the disability community often contend with. Further, their description emphasized the critical role the therapist served in facilitating deeper insight regarding their disability identity.

Similarly, Cat described how helpful it was for her therapist to validate her autistic experiences in pushing against the desire for normalcy. She shared:

> Yeah, not making me feel like a big alien. Because I think when … I guess do a lot of self-comparisons and knowing that I'm not entirely normal even though like … being autistic it's like, it's cool. Because you like you have an autistic identity but then you also want to be like everybody else.

Eva described a somewhat different experience exploring her multiple disabilities (psychological and neurodivergent) within the context of therapy:

> Yeah. I definitely have more experience talking about PTSD. And I don't know if I've necessarily talked about it in the sense that it's a disability, but I would say, yes, because when I talk to my therapist about it or my psychiatrist, it's … there's usually like this understanding of like, oh, well, you have PTSD, which then indicates that you might struggle with such, such, such. So, I feel like it's kinda like an unspoken agreement or understanding. Yeah, and I also would say like … I don't like … I don't go into my session and tell my therapist "oh like my PTSD is really bad this week," but I'll say like, "I had really bad panic attacks and like I couldn't turn in assignments" or like "I had a really bad flashback and took hours for me to ground myself" or something like that.

Eva's comments represent how discussions of disability may surface in more subtle ways where 'disability' is not necessarily explicitly acknowledged but conversations focusing on how her disability impacts her reaffirm her disability identity. She further elaborated on her experiences coming to terms with her neurodivergence. She elaborated:

> Yeah, and then for ADHD. That one is just still hard for me because I'm still like in the process of like accepting it. And a part of me feels like I'm just exaggerating things. And

> just because I'm like late and forgetful doesn't mean I have ADHD, which is true. But like there's more than just that going on. But I think it's also because I've only had one psychiatrist, like none of my therapists have really looked into that and so to me it's like well I've only had one person tell me that I have it. So, do I really have it?

Eva’s reflections highlight the various ways in which disability emerged as an identity within the context of therapy and how exploration and direct acknowledgement of the disability by the therapist influenced how she understood her disabilities. In Eva’s case, the nuances of acknowledgement and acceptance by herself and others appeared to influence how she oriented to her disability identities.

Sandie, who was diagnosed with Type 1 Diabetes and Graves’ disease discussed how the unique experience of acquiring a disability led her to pursue therapy. She reported:

> Yeah, you have your peers and stuff like that. And they can only be understanding for so much and for so long and … whereas in therapy it's just like, I feel like this is a problem. And you know it's hard to adjust, so getting that support and then recognizing like, okay this is what I need to work on or like you know. These feelings are pretty normal for, you know, the current state. Whereas it’s not like I grew up with this disability. So I think that's been like a very difficult transition and really hard for me to like really grasp and understand. Like my life is no longer gonna be like how it was 6 years ago and everything. … umm so it's definitely one of the biggest reasons kind of like why I pursued therapy.

She further elaborated on how acknowledging her disability identity led her to process the distinct change from identifying as able-bodied to someone living with a disability. She shared:

> It’s been quite a challenge because, oftentimes like, people have like, you know, different perspectives of like what the disability is and what it looks like. And according to the ADA Act, I think it is … diabetes is acknowledged and recognized as a disability. So, I just kinda remember sharing that experience or those experiences. And it’s, um, it is definitely … leads to kind of like, you know, the idea of wanting to reflect in on that process of how you went from being somebody who's, you know, completely, totally healthy, no issue. And then adjusting to this new identity where it's not like that anymore. And talking about that, I share … I feel like part of me has lost like a sense of, you know, my identity because I was a healthy like able body. Of course, I still am now. But there's certain things that I can't just go about my daily life. As where 6 years ago, I could just go out and go eat whatever I wanted and not have to worry about anything. Whereas now it's like I don't have the option of doing that because that can lead to high glucose levels or, you know, even like lead to like other serious issues of, you know, my A1C reaching a certain level. And having to like really make sense of that adjustment while also trying to get my career going has been like … it is difficult. But it has allowed me to really say and just share that experience.

Sandie’s comments capture the unique reality of living with an acquired disability (versus a congenital or developmental disability) and how that change brought a unique experience of loss for her.

Similar to Sandie, Beth reflected on engaging in psychotherapy after acquiring a traumatic brain injury (TBI) in high school though noted how her capacity to accept her disability significantly impacted how the extent to which she acknowledged her disability within the therapy context. She reported:

> I mean, … probably the unhelpful stuff in high school would have been like talking about and working with like, like what my disability is. Like in high school, confronting what it actually was and how it was affecting me back then was probably unhelpful, and I wasn't in a place where I wanted to accept that I had a disability. So trying to work with someone who was like, okay, well, what do we do because you have a disability? I would be like, well, fuck you. I don't … I don't have one. Look at me, I can talk fine. I work fine. I can do my homework fine. Like I've still got A's in all my classes. Like what do you mean I got a disability? When I was also in extended time classes and special smaller classes and like … again, arrogance of a 16-year-old.

Beth’s comments reflect how her resistance to accepting her disability identity influenced how she engaged in treatment in high school. Furthermore, her therapist continuing to attempt to address her disability without considering Beth’s identity development suggests the therapist lacked skills in understanding disability identity development.

Nova, Cat, Eva, Sandie, and Beth’s reflections on exploring their disability identities in the context of psychotherapy demonstrate the multidimensional experience of living with a disability and how disability type, onset, and status of acceptance contributed to how disability identity emerged within the context of therapy. Additionally, participants highlighted how their therapists played a unique role in their experience of exploring and understanding their disability identity.

Mental health

Many participants described varying mental health challenges and symptoms that either accompanied their disability or were exacerbated by the presence of their disability and highlighted how psychotherapy treatment appropriately targeted symptoms they experienced.

One participant, Anne, who acquired a spinal cord injury and was paralyzed from the chest down due to a motor vehicle accident, described how she benefited from engaging in psychotherapy which focused on driving-related anxiety. She shared:

> I've had a lot of anxiety driving because I was paralyzed in a car accident. I wasn't driving at the time but still driving made me nervous because you know I've seen what can happen when it goes wrong. So, so I thought you know what, I'm gonna work on that. And it was so helpful. I mean, I did EMDR and … and I didn't even realize how anxious I was till after I started doing therapy and I was like oh, like I'm driving and like, I feel light.

She further elaborated on how treatment altered the meaning and subsequent feelings that materialized when she reflected on the accident. She elaborated:

> She had me do EMDR literally from the time the car accident happened. Like when I woke up in the van, and I was like, oh, this isn't good, you know. And I processed that whole experience … to being in the hospital to you know all those things. So again, I don't think I had ever really gone that deep. And so it really made me change the experience to like something that happened to me and feeling like vulnerable and it was scary. To now, it's like it was like just an event that happened.

Anne’s comments capture an experience endorsed by other participants: experiencing mental health symptoms which were uniquely related to disability. Additionally, Anne’s experience highlights how psychotherapists can be well-situated to address mental health symptoms and challenges that are tied to the experience of disability.

Similar to Anne’s experience, Nova discussed how their neurodivergence (ADHD) intersected with their ability to sit with their emotions and reflected on the specific intervention their therapist utilized to address this difficulty. They shared:

> My current therapist forces me to sit in the current moment and wait, and just tell her how I am feeling right now. And like what my current status is and take a moment. And she very awkwardly like is silent, and I very awkwardly have to be silent. And you know until I can identify how I'm feeling right now. And I think I can do a good job of identifying and regulating complex emotions in my day-to-day life, but I don't do a good job with sitting with those emotions. So I think it's every session that's how we start. And I think it's been so beneficial for us to do that.

Nova’s experiences highlight how the therapist’s intentional choice to structure sessions in a unique way provided a designated time for Nova to sit with those emotions. Nova further highlighted how the consistent use of this intervention changed how they engage with therapy noting, “I feel like I get a sense of peace. And I think it's one of the reasons that I'm able to go deeper is because I sit with myself when I first start.” Nova’s experience not only reflects how their neurodivergence uniquely intertwined with facets of mental health but also reflects how appropriate interventions addressed how their neurodivergence played a role in the therapeutic process. And despite Nova experiencing the intervention as awkward, their therapeutic experience was that much richer because of it.

Similar to Nova, Sandie described a unique relationship between her anxiety and fluctuating blood sugar levels, a key component of managing Type 1 Diabetes. She described desiring for therapy sessions to unfold in a particular way and struggling to adjust when her therapist suggested experimenting with a specific intervention in session. However, she further reflected on how these interventions, despite being unplanned, helped her manage her disability. She reported:

> Because I know when I get extremely anxious a lot of things start to happen. Like, you know, anxiety comes in where it's like my body just does not handle stress well so if I'm under a lot of stress then my body will start to kind of like shut down. And you know, I notice I'm like having a runny nose. Or you know, my glucose is dropping down to a certain level. So, although sometimes it's like, oh, I don't want to do this, I want to talk about this, but then also giving me that space to say, okay, let's try this and doing this like one particular exercise. It kinda helps balance me out so where it's like, okay, in fact, I was okay with ending things right there. It's just like, for some reason I wanted to have like this whole structure going on. And, you know, being able to maintain that level of flexibility has helped me so much. Because I'm like, and everything is not gonna work well in the session or go as planned and that's okay. It's just like I need to be able to help regulate myself like my body, physically as well as like my emotional state. So that way if I feel like something starts to overwhelm me or just take control I'm able to be like, okay let me try this one tapping exercise. And being able to kinda like tap into, you know, the state of like calmness and like presence that I need to be at so that I don't have to worry about like, “oh, my sugar dropping because I just got this overwhelming like gusts of anxiety.” and having to struggle with that.

Although Sandie’s experience with her therapist reflects a struggle between her desire for sessions to follow a particular structure and the therapist’s recommendation for an intervention to decrease anxiety and the potential impact on her diabetes, it reflects how her therapist’s goal of equipping her with coping skills to manage her anxiety is ultimately beneficial for her.

Cat described living in a remote state for graduate training and the conflict between factors supportive of mood, sensory needs related to her autism, and therapy recommendations targeting this conflict. She shared:

> It's weird, and so a lot of people have low vitamin D stuff. And people get happy lights, and it's like this bright light is supposed to make you feel better … a happy light. So I was usually really happy because everything's dark, and I loved it. But then it was like, no, but you're still really depressed and here's why. And here's … you need to get a happy light and turn it on, even if it's just half an hour a day. It was like there, so that was interesting. Like things that you need as a human being … that you don't necessarily give … or that you don't necessarily seek out because of your own autism issues.

Anne, Nova, Sandie, and Cat's experiences capture how mental health needs in relation to their disability emerged in the therapeutic space in distinct, yet important ways. Nova and Cat's situations reflect how disability and mental health needs were in conflict with one another yet there was still space for a therapeutic intervention and recommendation to address the mental health needs. Anne and Sandie's accounts reflect the different ways that emotions like anxiety are intertwined with disability – either stemming from a disability-related experience or being distinctly separate from but influential in managing disability.

Disability and its extension to other areas of life

Participants acknowledged how the impact of living with a disability not only affected their lives but also extended to the lives of those around them. For many participants, talking about the challenges of one's disability on their relationships emerged in therapy and became a focus for discussion and intervention. Beth reflected on how her relationships with her family increased in complexity after she became pregnant. She shared:

> She’s also done family therapy with me, and she's talked to me and my husband because we’ve struggled with stuff. She's not a couple’s therapist, not a family therapist. But I've had things … I had to bring them in and like develop family contracts. When I was having my baby, there were some challenges, and I had to, like, adjust my relationship with my parents and get them to back the F off. And I had to work with my husband to like whatever. But I forgot where I was going with that. But it … yeah, she's just. Because the disability, and like most people's disability, it will kind of bleed into so many areas. It's hard to really separate what's the cause of what.

She further noted:

> But, yeah cause we've like, in family therapy, we wrote a family agreement slash contract with my family to get them to agree to certain things and like … changing how they handle things with me. Like having to, so in terms of my disability, having to get both of my parents to back off and recognize that I have an identity outside of my disability.

As Beth noted, her therapist expanded the zone of intervention to her family and intervened in a way that acknowledged the impact of her family’s difficulty in recognizing her identity outside of her traumatic brain injury. Beth further described individual-level interventions her therapist recommended to help Beth navigate how her family’s response to her disability was impacting her. She described:

> Like she had me at one point, come up with some sort of affirmation to say to myself daily …as like the homework I say to myself daily. So that I could like … well, still doing with family, I guess, be like, it's my life. I can make my own decisions.

Beth’s experiences highlight how therapy addressed the challenges she faced on both the intrapersonal and family level regarding her disability.

Clara described her attempts to process the impact of her traumatic brain injury on her mobility and ability to spend time with her family in therapy and noted difficulties feeling understood by her therapist. She shared:

> She was more focused on my relationship at the time. Well, same relationship. It was a lot newer then, and I shared some things about my partner that we're not pathological, but we're things that were just hard for me to navigate. And that's what she was focused on. Not necessarily how loving and kind my partner was. She was seeing my … she was seeing her as detrimental to me, and she's the best thing that ever happened to me. And if I didn't have her, I don't even know how I would have gotten through this. So, we were just kind of like missing each other. And with the medical, I think she was more focused on things that she was perceiving that weren't necessarily my issues, you know? Like … like the stairs, I'm sorry to keep coming back to that. It's just the most concrete example. She saw it as something I could overcome, which I agreed. But in the moment, there were so many things that were challenging in the relationship for us to be together. So I thought, well, here's my girlfriend going off and getting her own place. Which is wonderful, but I don't get to be a part of that. You know, whereas she saw it as well, just work harder. Go to PT and you'll be fine!

Clara’s experience demonstrates the disconnect she experienced with her therapist and how the clinicians’ inability to acknowledge and center the salience of disability-related issues contributed to that disconnect.

Disability does not just impact the present lives of individuals but also has implications for the future. Sandie reflected on how Graves’ disease presented potential future challenges given its impact on fertility. She reported:

> Yeah, so … regarding Graves disease. Um that's been a challenge to just kind of like talk about in a therapy session. But I also talk about it as well just because … I don't know if you're too familiar with Graves disease, but like it's just like, you know. You have an overactive thyroid where it produces too much hormone in which like it can lead to like rapid weight loss, um, brain fog and like fatigue and that kind of stuff. Like, some severe cases you have like the protruding of the eyes out and everything. And I think that's just due to like the higher like state of … your kind of thyroid … hormone production just kinda like, oh going into overdrive and everything. And I talk about it because I'm like, it definitely can affect your, um, fertility and the ability of wanting to have kids. So I often talk about that in session. I'm like, you know, although I don't have a, a steady boyfriend, I would say, or a boyfriend even for that matter. I talk about that. I'm just like, you know, I wanna get married. I want to have kids, you know, once I get my degree and stuff done. But then also just the fact of having this hormone condition makes me so scared because like yeah. Like everyone, the idea of like, you know, not being able to have children on my own, like significantly scared me, because that's something that I've always wanted. And you know, I wanna be, I wanna be a wife and I want to be a mother and all those things. But if they are not regulated to a steady level or steady point. Then, you know, that makes that process so much more difficult. So, I wasn't able to kinda like share this with my therapist as of yet.

Beth, Clara, and Sandie’s experiences capture how disability extends to current relationships as well as future relationships and reflect the potential role therapy can play to assist clients in navigating these concerns. Beth’s experiences demonstrate how disability, when appropriately centered in therapy within the patient’s broader life experiences, can inform interventions to equip individuals in navigating interpersonal difficulties related to their disability. While Clara's experiences capture the disconnect that happens when therapists don't appropriately attend to the salience and impact of living with a disability. Sandie's experiences reflect the importance of therapists considering how disability may impact an individual's life in the future and make space for clients to address these concerns within therapy.

Theme 2: Affirming and supportive therapy

The next major theme reflects the psychotherapy experiences where clinicians demonstrated a supportive and affirming orientation towards the participants' disability experiences. Sandie described a particularly poignant experience where she discussed encountering stereotypical comments and questions about her diabetes with her therapist. She shared:

> Part of me feels like I kept it in so long because I knew if I would talk … I know if I would talk to certain people, it will be that lack of understanding. Or they often jump like, "oh, you know, is it because you have too much sugar" or you … And it's just kind of like these kinda like stereotypical like questions or like you know comments and stuff like that. And it's just like, you people tend to not think that you could develop the diabetes at … pretty much at any age. And it doesn't have to be Type two like it could be Type one or you know genetics and stuff that kind of come in and play a role into that. So, sharing that experience and then like having the therapist validate that experience for me. And I think it's just … it's heartwarming in a sense. Because it's like, now I feel so comfortable that I can share this. And talk about it without feeling the shame.

She further elaborated on her therapist's response to her difficulties navigating medical care. She added:

> But then also just sharing in the space of like going to see different providers and one provider says, you know, this. Or just kinda, like, having to go through separate different providers to get the actual care and treatment that I need. Where they question whether it's type one or type 2. And still, it's like that with my primary care provider. And I kind of discuss that with the therapist and let her know that, like, it's so frustrating because it's like, no matter what I say, it's not taken into consideration. And being able to share that in therapy and have that taken to consideration, alleviates me in a sense to where it's like okay somebody is actually listening to me, and someone isn't going off … based off of like the weight and stuff like that. It's just someone who's actually listening to me and hearing what I'm saying. And you know, not even so much reacting or responding. It's just kinda like giving me that space to just really be there, and just vent and just like let everything out, um in the process. It has definitely like made me a little bit more of accepting … to like … accepting of, you know, my condition and recognizing that like you know, this is what I have, but it doesn't have to define me.

Sandie's experiences demonstrated how deeply impactful it was for her therapist to respond her to experiences of being marginalized by friends and medical providers from an attentive and affirming stance.

Clara, a participant who experienced a traumatic brain injury resulting from a Covid-19 infection and engaged in therapy while completing inpatient rehabilitation, described how her therapist reinforced the strength of the therapeutic bond and created an affirming therapeutic space with how she attended to Clara's need for mobility assistance. Clara attended therapy via Zoom while she completed rehabilitation treatment and as a result, utilized a conference room in the rehab hospital for her therapy sessions due to lack of privacy in her room. She shared:

> So before, I said I'm not someone who's really big into CBT or any of those thought types of orientations. And I'm more psychodynamic, relational and leaning, not hardcore, but you know more modern. And so my first go-to in answering your question is, even in therapy, it's about the people and the relationship. And we didn't have much of a foundation. Right? With my current therapist. It’s what you do. It's how you do it. It's the messages you're sending. It's the feeling. People don't remember what you say. They do remember how they feel when they're with you. And with her, that went a long way. I don't care what her orientation is at this point, I'm sold. Because we have that connection now. She made me feel safe. She made me feel like when I was in that conference room, she wasn't leaving me until we figured out a plan for me to get back to my room. She made it clear she had no one after me. And if I couldn't get back to my room, I was to call her. And she would help me figure it out if it meant calling the rehab for me. Right? Cause my brain was working, but I was tired. I was overwhelmed. I could have called myself, but I didn't think about it, you know?

She further added:

> She never commented on the things I can't do. You know, she was very supportive not toxically positive either, but supportive on like, “oh well since last week you sound, you know, so much better with your speech. Or wow I can't believe you're already doing that physical thing in PT!” Or you know very building me up.

Clara’s comments capture her therapist’s skill in attending to Clara’s needs both in the moment as well as broadly creating a sense of safety through advocacy. Her therapist’s affirming care extended beyond the therapeutic hour and displayed a commitment to helping Clara navigate barriers should they emerge once therapy was complete. Her therapist also acknowledged Clara’s physical reality from a balanced, strengths-based perspective.

Eva, a participant living with post-traumatic stress disorder, major depressive disorder, and attention-deficit / hyperactivity disorder acknowledged the meaningfulness of her therapist’s ability to remind her of her worth and create a therapeutic space where authenticity and acceptance were prioritized. She shared:

> I mean, I'm fortunate enough that I can say I've had more than I can count … sessions that have been helpful. But to narrow it down, I think just like sessions where I'm reminded that I like am worthy of good things. And that not everything that happened to me was my fault. Yeah, I think just being able to have a space, when I've connected with therapists, like have a space where I feel like, okay I can let things out and I won't feel like a burden to them. Or I won't feel like I'm too much … like they can handle it. Yeah, like just being able to have that space where like I feel like I can truly express myself. And be accepted at the end of it has been helpful.

Beth acknowledged how she important it was for her therapist to willingly accommodate her evolving needs regarding the impact of her disability on her life noting, “Her willingness to help support me wherever I needed it, has been really helpful cause I often didn't know how to talk to my parents about that kind of stuff.” Beth’s comments capture how a collaborative approach to therapy characterized by flexibility and willingness to accommodate changing needs within therapy bolstered her positive experiences in therapy. She further discussed how people in her life overemphasized the presence of her disability and how therapy was an important space to counteract that reality. She further shared:

> I think, you know, this is true of most disabilities, it's hard for people to see the person outside the disability and especially in therapy. Like that's what I think I love about my therapist is that she … I think what’s she done, and also kind of helped me see for myself to be my own clinician, is validate me outside of my injury or disability.

Sandie, Clara, Eva, and Beth’s experiences reflect the importance of centering disability experiences from an affirming perspective where their realities, both positive and challenging, were acknowledged. Their experiences also highlight how the presence of disability did not alter the therapists’ ability to remain empathic and nonjudgmental.

Theme 3: Interpersonal invalidation and marginalization in the therapeutic context

While many participants described supportive and affirming therapeutic experiences, participants also described encountering therapist’s negative attitudes, false assumptions, and behaviors regarding the presence of disability, participant’s behaviors, and participant’s realities and needs while simultaneously excluding their input and perspective. Two subthemes comprise this main theme and include therapists overemphasizing the presence of disability and ignoring the salience of one’s disability.

Inconsideration of disability

Participants described numerous encounters within therapy where their therapist failed to consider how their disability may be salient in the interpersonal interactions between the therapist and participant. The inability for therapists to adequately consider the salience of disability within interpersonal reactions led to participants having to adjust to fit the expectations of the therapist. Nova described an experience where their therapist commented on their movement in session. They described:

> That has happened in a therapy session, not with the queerness though, where I'll be adjusting and they'll be like, "You look uncomfortable" and I'll be like, "I am, I have ADHD, I have to move."

Nova further elaborated:

> And, so when I got called out for, and in a kind way it was not a negative way, for moving around in my chair and being uncomfortable, I learned okay well what can I do so that this does not come up and distract us? So I learned to go in, grab a pillow, and sit with a pillow over me. And I just sit with the pillow over me. Then she asked, she's like, "oh, do you feel unsafe cause you have a pillow?" No, but I had that conversation one time and it didn't happen again. So like that's something I learned to do that was with one therapist.

Nova's experiences begin to capture how disability manifested in interactions between the therapist and participants and how therapists failed to appropriately consider how disability may influence verbal and non-verbal body language and behavior. In Nova's case, they even attempted to accommodate the interaction by adjusting, and their therapist still failed to understand the salience of Nova's ADHD in this context.

Cat described exploring psychodynamic therapy and demonstrated how her therapist failed to adequately conceptualize and understand how her Autism influenced her conversational style. She shared:

> It was like a lot of talk, but she was so Freudian. Because I relate to things as being squishy, like warm and fuzzy and comfortable. And I was just talking about things being squishy. And she was like, "Are you talking about your mother's breast?" So that was bizarre. Like, really weird.

She further elaborated about having to mask when engaging with non-autistic therapists. She commented:

> I’ll greet people with “meow” or “ugabuga,” and she's cool with that. I can't normally do that with regular therapy folks. So they're like, “Oh.” *(Cat mimics writing down observations)* And they write it down and you know, oh my gosh, no I'm just saying hello.

Both Nova and Cat’s experiences highlight interpersonal interactions where clinicians failed to understand how their disability was at play. Importantly, these interactions also created a burden where the participant was responsible for accommodating the interaction due to the therapist’s incompetency regarding the participants disability.

Overemphasis of disability

Participants also described different, but equally invalidating, experiences where their therapist overemphasized the importance of their disability. Anne described her attempts to discuss her fears about being a therapist with a discernable physical disability. She shared:

> There was one comment that my therapist made that I was like, I don't think so. She said, well you know, no, no one would … you'd be much better helping people with disabilities than someone who doesn't have disabilities. And I don't think that's true. Because we were talking about me becoming a psychologist. And, I don't think that's true at all. I think I might be worse for some people to be honest with you. Just because I'm like … let's go, you know, let's get this moving, you know what I'm saying? So, and I thought no. I disagree. I … and I thought, that's interesting that she thinks that cause she didn't come across that way at all to me. But it's like she had that thought that like people who experience something are better at helping other people who've gone through it. And

> yeah, maybe they have more of an awareness, but I don't know that that means their skills are any better, you know? So I thought that was interesting. I don't know that I'd be better than a non-disabled person helping a person with a disability, truly.

She provided additional details about this interacting and elaborated:

> No, and I, I think the issue, I think what I was talking about was my fear being a therapist in a wheelchair and that my clients would perceive me as like incompetent. And at … it was like my own insecurities I was talking about … that I was afraid of that. That they would be like, well, I can't tell her my problems because look at what she's gone through. You know, she's, she's disabled. You know, so that was my fear. And then that was her response. Like that I could probably help people more in a lot of ways because I was disabled, but also that point of I could help disabled people more too. Which I was like, nah … nah. Yeah, so that yeah, that always kind of stuck with me. Like, huh that was weird.

Anne's experiences begin to capture participants experiences where therapists overemphasize the salience of disability, and in this case, assuming Anne would be a better match to work with other disabled clients. Additionally, the therapist neglected to acknowledge the ways in which Anne's disability was salient, and Anne's fears about being a disabled therapist remained unaddressed.

Nova described similar experiences where their therapist made false assumptions based on the presence of their ADHD noting, "I think at the time I was starting to like apply to graduate schools so there was like stress there. And I think she just associated stress with my neurodivergency." They further elaborated:

> So this came up when I was like coming, like deciding to go to graduate school, there was this like expectation of like, you know, you're gonna have to do readings like all of this, you know, you probably should get back on medication now. That was something that one of them told me, and I respect that they told me with their best knowledge, but they were like "you haven't been on medication since you were a kid. You should probably do it this year before you actually get into graduate school so it's had time to get in your system." And I did it, and (sighs) I don't, it really wasn't helpful. Like it, Adderall wasn't helpful for me at the time. Vyvanse was not generic, and I heard some good things but I could not afford to switch to Vyvanse and that was the only other one I wanted to experiment with at the time. But it was like, it just wasn't helping it, honestly it just … it was like I was on speed. I was doing the things I was doing. I was just doing them faster and so there was no, like addiction to it, but like I would understand that I would, I couldn't have coffee on the mornings when I did that because I was gonna be like going a mile a minute. So I think … I guess to sum it up. I think assuming what the answer is. And assuming that there's something that I need because I'm neurodivergent rather than just helping me manage.

Both Anne and Nova’s experiences highlight how participants had to navigate therapeutic interactions where they were attempting to better understand how to navigate current life stressors – applying to graduate school and exploring fears about being a disabled psychologist and were instead met with inappropriate responses and recommendations that downplayed the real issues at hand and overexaggerated the salience of disability.

Theme 4: Role of salient social identities

Many participants described the role of their salient social identities and how either sharing or not sharing these identities with their therapist influenced their psychotherapy experiences. Clara described how acquiring her physical disability changed the barriers she encountered and the difficulty her therapist had in empathizing with her experiences. She expressed:

> You don't have to have a particular disorder, or issue, [or] presenting problem to treat someone with that, right? You don't have to have depression to know what depression is. However, I find that a lot of people just don't fully understand how a disability impacts a person if they've not experienced it. I have worked with people with disabilities for 20 years before changing careers for, you know, psychology. And I thought I knew, and I did not. So, I think that's been probably the biggest challenge. You know, before all of this when it was *just*, which is, I hate that word, but *just* my knee. I had therapists who I no longer work with who could not empathize entirely with why it was so important to me to be able to take stairs. And the emotional loadedness of that. And she thought, “Well you’ll get there. This is a knee injury. It's gonna go away.” Right, but that impacts my ability to see my parents because if I want to see them I have to sleep upstairs which is 14 steps. I had someone very significant in my life. Who moved into a second-floor apartment. No elevator. Well, that cuts her out. So it … it was tough to have to explain why everything was important to me.

She further added:

> And with my current therapist, who has much more of an understanding of health psychology and has worked in … in medical settings. Still, it's … it's a bit of a challenge to have her really understand. I think she asked me if we do ball throwing in PT because

> that works on balance. Well, I'm working on standing upright, not holding on to anything. I can't have flying objects coming in. We're not there yet, you know? So it's, you're automatically in this role of having to teach others. You know, when really, you're trying to seek help for yourself.

Clara’s comments begin to capture the disconnect that occurred in cross-cultural therapy interactions, non-disabled therapist working with disabled clients. Her experiences capture how she had to assume the additional burden of teaching to improve her therapists’ disability competence.

Cat’s experiences reflect how sharing salient identities with therapist increased feeling understood, authenticity in interactions, and freedom to openly discussed disability-related issues, noting, “What I like about my therapist now is that she gets it because she lives it, and I can be as weird as I want.” She further added:

> I think like if you're living it and breathing it, you just understand and there's just kind of like this underlying dialogue like we're all on this bizarre planet together, and we're kind of experiencing the same things similarly that everybody just seems to just get.

She provided additional details noting the freedom to discuss disability-related issues. She shared:

> Oh, it's huge. I can talk to her about my sensory issues like with the bright lights and share with her how I prefer black and the sun is painful. And she's all over it cause same for her too, so. And she's like, oh my gosh, yeah, I get it. I mean, it's as severe as mine, but. Yeah, it's just nice. That someone gets it. They're like, “What? You don't like, vegetables? What's wrong with you?” It's like, yeah, no, it's a thing. (laughs)

Cat’s experiences reflect how engaging in psychotherapy with an Autistic therapist created a shared understanding about what it means to navigate and experience the world in a drastically different way than the majority of individuals and how the burden of teaching culturally relevant information was removed. Her experiences also reflect how sharing her Autistic identity with her therapist facilitated her ability to engage with her therapist from a place of authenticity and removed the burden of needing to mask.

Eva described her experiences navigating cross-cultural therapy along the lines of racial, ethnic, and linguistic diversity and shared how differing salient identities created additional burdens of having to both explain and teach cultural factors as well as translate cultural concepts to her non-Spanish speaking therapists. She shared:

> I think in the beginning, like my first few therapists, a common like struggle was the time it would take - well, not the first Latina therapist – but with most therapists it's like the time it takes to explain cultural factors that impact me. Or the like the yeah, I guess you could call them cultural factors because like my parents or at least just my family history, I'll say that. My family background … because not everyone in the culture has the same experience. But like my parents are both from Mexico, so I'm like the first generation that was born and raised here. Which comes with like its own stuff. And then there was, I grew up like speaking Spanish, my mom only speaks Spanish and so there were times when like something was happening in my family or I would want to express things in Spanish because it was just easier for me because I have the conversations with my mom in Spanish or like that … I don't know that's just what comes up naturally and then it would feel like I was taking up more time because I was trying to figure out like what's the right translation for this? Or like how do I explain this in a way that's fitting? And

> those are the moments when I was like, oh, like it would be so nice to just have a therapist like I could say this in Spanish to them and they knew what I meant. Yeah, so I know that's not something that like they did on purpose, but it was unhelpful for my process because I'd be sharing things and trying to get stuff out and then it would like force me to stop to translate things or explain like cultural pieces that they maybe didn't … weren't aware existed or things like that.

When reflecting on how her therapy experiences might change if she worked with a Latina therapist who share similar values around systems of oppression, she shared:

> Hmm. *(deep sigh)* Well, I feel like it'd be like the ideal therapeutic relationship for me. But it's just, that's not available, like there's not a lot of therapists or psychologists I know of. I don't know, like I'm smiling just thinking about it because I'm like, oh *(deep sigh)* like I feel like that would be so much easier, and I'd get the services that I need. And I wouldn't be settling when it comes to my needs.

Eva's experiences reflect how her disability identity is intertwined with other social identities and that holding multiple, marginalized identities brings with it unique needs for the therapeutic space. When those needs aren't met, engaging in therapy changes in challenging ways.

Similar to Eva, Sandie described how beneficial it would be for her to have the opportunity to work with a Black female therapist. She reported:

> Whereas if like, you know, if I was connected with a Black female, I would feel like, okay, this person definitely understands me. This person can support me the way I need to be supported because you know. Yeah, we may have like shared experiences similar or … yes, similar life … shared experiences in terms of like our identity. But then also just feeling like, okay, you know what it's like, like even if they don't, like, they kind of like

> have you know, they're able to be a little bit more relatable with like certain experiences. Or just kinda like sharing my experiences of what is like trying to be a grad student and you know, I know that's something that they have experienced before as well. And have their like, you know, obstacles that they had to encounter with trying to, you know, get to that level and point in their career and everything. So I feel like, it would just be that big component of like relatability and that strong sense of connection where it's just kind of like I’m not so much speaking to a friend, but I’m speaking to a professional who understands me.

Clara, Cat, Eva, and Sandie’s experiences demonstrate the unique role of salient identities within the therapeutic space and how cultural competency created room for unique needs to be met, disability-related or otherwise. Their experiences underscore the unique relief that participants described when engaging with therapists who simply “got it” while also highlighting the additional emotional load required when engaging in cross-cultural therapeutic interactions where competency was lacking.

Theme 5: Institutional and Environmental Imprint

Participants described the unique imprint of the environments and institutions where they engaged in psychotherapy and how spaces and places impacted attending and engaging in therapy. Two subthemes comprise the overarching theme and reflect how institutions and environments accommodated their needs and were uniquely accessible or introduced additional challenges and barriers in either attending and/or engaging in therapy.

Burden of unmet needs

Many participants described the assumed burden when encountering and navigating psychotherapy spaces and that did not match their disability-related needs. For many this included not only the physical environment but also included institutional procedures. Clara described:

> You know, when you're in a rehab. And you know, I'm not talking substance abuse. I'm talking about what looks like and feels like a hospital setting. I had a roommate, you know, like how am I having Zooms for therapy? I had to find another space. And when I was in my room and didn't have a roommate, is someone going to come in? And you know it's just the wall is up.

For Clara, the unexpected change in her ability to physically attend therapy visits as well as hospitalization meant a temporary change in having agency over her space. Furthermore, this created an additional emotional barrier to fully engaging in therapy due to the inability to ensure privacy. She also reflected on the new barriers she encountered upon leaving the hospital and resuming in-person sessions. She shared:

> Yeah, it's been ... everything is such a trial-and-error experiment. But what I'm learning is, you know, not every building is up to ADA code, right? And if they were built before 1985 or 75? I can't remember right … they don't have to be. So, her building does not have automatic door openers. And it has a curb … like there's parking and a curb that you have to step up onto in order to get into the building. If you can't do that, you have to go all the way to the street to the sidewalk and then go around a big bush and then you're on that main where I would have had to step up the curb. So, I can't do curbs yet. I'm working on it, but no. So that's a challenge just getting into the building. Getting there, I can't drive yet. And I can't take an Uber because how many Ubers are going to get out of their car and put my wheelchair in their trunk? I can get in and out of cars, fine. So they're not going to do that. They're not going to get out of their car to open the door for

> me either, right? So … and I could take an accessible Uber, but they're few and far between, and they charge more. So, I now have someone who is kind of like my personal Uber. And well she lives across the street, friend of a friend, doesn't have a job, needs money. So she drives me to all my appointments.

When reflecting on how her therapeutic experiences may change if structural barriers weren't presented, she shared:

> Well, I'm pretty determined and don't let a whole lot get in my way so. In the wheelchair, the first thing I did was figure out how to get through doors. So I'm pretty good at that. The walker I can't get. I've been practicing, but it's a balance thing. Because doors close automatically even if they don't open automatically right. So, they just touch me, and I'll fall. So, it would make a huge difference even with just automatic doors, so I didn't have the anxiety of, am I gonna make it through? Or forget about making it through. I have to hold the door with my body … the back, my back against the door and slide through because I can't open it with one arm and walk with my walker on the other. So, I think for, for fear and anxiety of what it would do to me, that would be enough of a difference.

Clara's experiences capture the additional emotional burden she assumed when encountering structural barriers in the environment that contained her therapist's office. She also reflected on how the traditional, 50-minute therapy session conflicted speech difficulties related to her TBI. She shared:

> For me, I have never felt such a time pressure before. Not from her, not where she was rushing me at all, but it was this feeling of, I haven't talked to you. This has been so scary and so awful. I have 800 things to convey but I can't do that. I can't talk very fast.

She also reflected on how her experience would change if the format accommodated her needs. She noted:

> Oh. I wouldn't have felt so pressured, and kind of, just scared, you know? Like that's weird to say I guess because of just the speech issue but I was alone there, you know, and I, I just felt like if I had more time, I could have felt the feelings in the moment. And not just had to spend all this time on the background, you know? Well, I haven't seen you for 3 weeks and 3 weeks in the regular world can be long but in a hospital or rehab setting it's you know again there are 800 things that happened. And you're not … you don't have time to do all of the background with this slowed speech and feel the emotions.

Clara's experiences with the institutional barrier of therapy of a time-limited format reflect barriers to engagement as well as an additional emotional burden she incurred when participating in therapy that did not match her needs.

Eva described similar institutional barriers where her therapist's lack of knowledge created a barrier to accessing care for multiple disabilities. She shared:

> And then when I talk to my therapist about it. Because I was like, I feel like it's really causing like problems like in my work, like my reputation, people think that like I'm … I don't care and things like that or like I'm not trying. And then like I came out at my brother's wedding, but I was late to the services, and I felt like really horrible about that. And then my therapist was like, well, like I specialize in trauma and that's what I can help you with. So I kinda just felt like, okay, well, I'm not gonna talk about my ADHD with her because she doesn't know how to help me with that. But I also don't wanna let her go because it's been so hard to find a therapist that I connect with. So if it comes between like having to like restart the process of finding a therapist that not only fits my needs and

> like has experience working with like multiple traumas and also now like can help me with my ADHD. Or I can just stick with this therapist who is doing a really great job of helping me with my trauma and like the ADHD stuff like I can figure it out later or as I don't know on the side. So I decided to stick with this therapist.

As Eva highlighted, locating a therapist that could appropriately accommodate her multiple disabilities meant she would have to restart her therapist search, a decision that would require an additional invest of time and emotional energy in locating a clinician better suited to meet her needs a. Clara and Eva's experiences capture not only the numerous environmental, structural, and institutional barriers that participants described but also demonstrate the burden of inaccessibility. Participation and engagement came at a cost, and instead of the environments and institutions being designed in such a way that would accommodate their needs, they assumed the burden. To remain in the space and engage with therapy meant a tradeoff occurred in that they were unable to address fully their mental health needs. Furthermore, most participants described remaining in treatment even when encountering barriers demonstrating resolve and the ability to make the best of less-than ideal situations.

Met needs

Participants described therapy environments that accommodated their disability-related needs and allowed them to remain engaged in the therapeutic process due to how the physical space around them matched their needs. Eva described how she engaged with the physical environment to accommodate Eva's PTSD. She shared:

> It's funny that you asked this question. I don't think I've ever been asked this but she like had like a rug on the floor, she had like 2 different seats that I can choose from and one was like more of a comfy like couch seat but just for one person I forget what those are

> called. But anyways, I would always like sit in that one and sometimes she would notice like how shaky I was getting. And she started to like offer the option of sitting on the floor and that worked better for me. So I liked that and then I would touch the rug. And she had like pretty art pictures. And then she had this one rock lamp, like a salt … salt rock lamp. That I actually ended up buying one for myself years later, because I loved it so much. But she would use this also like a grounding technique. Like I remember her saying like, Okay, just focus on something in the room, and I always would like look at the lamp and it would just calm me. And I loved the color. And we would talk about how it reminded me of the sunset. She had some other pieces that like we're good conversation starters, and in the beginning, she would bring her dog who was getting trained as a therapy dog. So, I loved petting the dog. And at that time, I didn't have my emotional support dog. And I really wanted a dog, so it was just, I like loved it. Yeah. Yeah.

Eva's experiences capture how the intentional environmental elements of the therapeutic space grounded her in moments of emotional dysregulation and allowed her to emotionally return to the space and engage in session.

Nova described similar experiences where their therapist's space accommodated their neurodivergency. They reported:

> Another therapist worked pretty balanced with adolescents and with adults. And she would have like fidget toys. And when I told her I had, I was diagnosed with ADHD, she was like, "oh, well you can play with the fidget toy while we're going, uh while we're doing therapy" and I was like "fantastic!" so like she was that was probably my favorite therapy experience. First of all, she was my favorite therapist that I've ever had but she just … It didn't seem like it was a barrier ...

Nova’s experiences demonstrated how instead of them having to adjust to the therapist and the space like they described earlier when sitting with a pillow to prevent them from distracting a different therapist, they able to engage authentically. Importantly, the therapist’s environment was already structured in such a way to meet Nova’s needs.

Cat reflected on her varying therapeutic experiences and noted the elements of different environments that allowed her to shift her gaze when eye contact became uncomfortable. She shared:

> Yeah, so they all differed. I felt most comfortable when the rooms were really dark, when there was a lot of plants, light was dim. If it's too clinically, it's just it “ugh”. It just, you know, if things look sterile or too hospitality, I just … trying to remember … so in [Redacted], the woman's office, woman that I saw, she had plants. It was dimly lit. She was cool, it was warm and fuzzy. The guy that I saw, it was bright lights and very sterile. There were a couple interesting things in his room but wasn't like the other person's. Cause it was just fun to look at stuff and you can you know … like for me, sometimes looking at people in the eye can be kind of hard. And it's just distracting, but I like to like look away and then my brain just (motions with hands). That was cool.

Cat also discussed how having the option of engaging in teletherapy increased access and participation for her. She described:

> Uh huh, which is really helpful. Because, I think for me, like just to get there, like for me, like I'm an hour or so outside of [Redacted City]. And then the stress of having to find parking and … I'm not a city girl at all. Like I hate cities. I have my routine like how I get to and from work. I know my streets. If I'm really spunky that day, I can veer a little bit out of my routine and go to a … hit a grocery store or something. But otherwise, I get

> really anxious when it's like. Yeah, if it's something else, so if it's outside, like I have to go to an appointment that's an hour away. I've got a deal with parking. I've got to find, you know, it's just. Takes a lot of energy, so it's about a 3-hour trip. An hour there, you sit in treatment for an hour and then you come back, that's another hour. And I'm just like, you, you know what? No, and I have time. I don't want to go, but since she's online, it's really cool.

Clara, who acquired a traumatic brain injury after she had started working with her therapist, noted how the flexibility in changing the arrangement of furniture in her therapist's office allowed her to attend both when she used a wheelchair as well as a walker. She shared:

> So her physical environment, her office is actually very conducive to a wheelchair or sometimes I go with my walker. I don't think she had that in mind. You know, I know I'm the only one that she has on her caseload that has this kind of physical disability, but she has a coffee table that's like a chest and she just slides it out of the way real easy. I can choose to stay in my wheelchair if I'm in the wheelchair. I can choose to get up and sit on her couch when I want to. Obviously with the walker, I have to sit on her couch and that's very easy to do. And, most importantly, she is very thoughtful and kind. So. I always have the questions of, you know, do you want those pillows? Do you want them out of the way? She's got a ton of pillows. And she has different options for seating because I think she has groups. So, it's a long couch. There's two single couch chair type things. And I can sit wherever I want. And when I leave, she always opens the main office suite door for me so I can get out that way.

While Clara notes that her therapist perhaps did not intentionally create the space to accommodate someone who uses mobility aids, the therapist was flexible in re-arranging the space to accommodate Clara. Additionally, her therapist assisted Clara in exiting the suite by accompanying her beyond the therapeutic space and ensuring ease of exit. Clara also elaborated on how her therapist accommodated financially due to her unexpected hospitalization and rehabilitation treatment. She noted:

> She was very compassionate, very kind, very patient. You know, never asked me about payment. Mentioned like, well, we'll figure it out. Don't worry about it. So I don't think I paid her for about a month until I was home and could send a check, you know, those little things that go a long way.

Nova, Eva, Cat, and Clara’s experiences capture how environmental elements and institutional procedures (e.g., format of teletherapy, policies on payment) met the participants’ needs for access and participation. Furthermore, they reflect how the choices and actions of their therapists, whether intentionally or unintentionally, led to access and engagement. This reality reflects how therapists, whether aware or not, were an active participant in meeting the needs of their clients.

CHAPTER 5

Discussion

To my knowledge, this is the first qualitative study to explore more broadly the therapy experiences of adults with any type of disability. Previous studies (Conner et al., 2023; Hunt et al., 2006) explored the therapy experiences of people with physical disabilities. This study's broad focus on disability was intentional and guided by previous calls for researchers to broaden the conceptualization of disability as a matter of human diversity (Bogart & Dunn, 2019) and expand research on the psychotherapy experiences of disabled individuals (Olkin, 2017). Participants' disabilities included neurodivergence (ADHD, Autism), psychological/emotional (Major Depressive Disorder, PTSD), physical/mobility (spinal cord injury, mobility disability resulting from COVID-19 infection), acquired brain injuries (COVID-19 infection, traumatic brain injury), and chronic illness (Type 1 Diabetes and Graves' Disease). This study was guided by the following research questions: (a) what are the experiences of people with disabilities in individual therapy settings; (b) what, if any, is the essence of counseling that people with disabilities perceive and described as helpful; and (c) what, if any, is the essence of counseling that people with disabilities perceive and described as unhelpful.

Summary of Results

There were five themes identified from the data (a) multi-faceted experience of living with a disability; (b) affirming and supportive therapeutic interactions; (c) interpersonal invalidation and marginalization in therapeutic interactions; (d) role of salient social identities; and (e) institutional and environmental imprint.

Multi-faceted experience of living with a disability

Participants described therapeutic encounters characterized by multi-dimensional elements of living with a disability which included attempts to navigate their disability identity, navigating mental health challenges, and working through how their disability extended into other areas of their lives, particularly their relationships with others and their roles as partners, parents, adult children, and desire to have children. These themes were consistent with previous research (Conner et al., 2023; Hunt et al., 2006) though previous studies conceptualized these elements more broadly in themes reflecting counselor effectiveness, affirming and supportive approaches, and awareness and education. Participants experiences in this study coupled with previous scholarship provide strong evidence that mental health professionals should hold a basic understanding of disability identity development and hone skills in attending to identity with clients when appropriate.

Living with a disability did not preclude participants from experiencing mental health challenges. Paralleling the multi-faceted nature of disability, mental health challenges emerged in participants’ lives in a similarly diverse way. For some participants, mental health challenges pre-dated the onset of disability and disability sometimes exacerbated these challenges. For others, mental health challenges were inextricably intertwined with mental health challenges which provided unique ways for mental health professionals to intervene and support participants’ growth. Similarly, Hunt and colleagues (2006) demonstrated themes of depression amongst disabled lesbians, and Conner and colleagues (2023) found that therapy was beneficial for participants navigating both psychological and physical symptoms. Depression was an experience many participants endorsed in this study. Participants’ experiences suggest that therapists should assess clients for mental health symptoms just as they would for non-disabled clients, while keeping in mind how disability may be intertwined with symptoms of concern.

Disability did not just impact the individuals but extended into other areas of their lives, impacting relationships with friends and family. Participants described mixed experiences in their attempts to address these issues within therapy. Therapists who responded with flexibility and displayed a willingness to expand therapy to include significant others and family members proved beneficial for participants. On the other hand, the therapeutic relationship was hindered when the clinician was unskilled in conceptualizing the salience of disability with the context of relationships. Results from Hunt and colleagues' (2006) study reflected some participant experiences discussing their lesbian identity in terms of their relationships with others but the impact of disability on relationships was not discussed. Thus, this theme appears to be distinctly different from similar studies. Existing literature exploring disability within family systems (Gill, 1994, Risdal & Singer, 2004) and marriage and partnerships (Brownridge, 2006; Gill, 1996; Hostyn & Maes, 2009) highlight how disability with relationships is an important area of consideration for PWD. Olkin (2017) emphasizes the importance of considering how disability uniquely manifests in relationships in a positive way (e.g., resilience, pride) despite the traditional narrative of disability as a burden.

Affirming and supportive therapy

Participants described affirming and supportive psychotherapy experiences regarding their disability as well as in other life domains. This provides evidence alongside previous research (Conner et al., 2023; Hunt et al., 2006) that psychotherapy may assist people with disabilities with improving their psychological and emotional well-being. Notably, positive experiences regarding living with a disability were built off therapists' use of fundamental skills including empathy, nonjudgment, and a focus on the therapeutic relationship meaning the presence of participants' disabilities did not change the therapists' stance towards treatment. Participants' affirming experiences included validation of their experiences with marginalization, advocacy for disability-related needs, approaching disability from a strengths-based perspective, and flexibility in addressing disability-related needs. These findings support previous research (Conner et al., 2023; Hunt et al., 2006) and also align with Olkin's Disability-Affirmative Therapy (DA-T) (2017). DA-T was developed as a tool for mental health professionals to appropriately conceptualize how disability plays a role in a client's life. It emphasizes both the client's experience with disability along nine different dimensions as well as the importance of clinicians adopting an affirming orientation towards disability. DA-T encourages clinicians to take a collaborative approach towards therapy which is grounded in disability knowledge, advocacy, and conceptualizes disability as an aspect of human diversity.

Interpersonal Invalidation and Marginalization in Therapeutic Interactions

Participants described encountering therapists' biases regarding disability which were expressed in a variety of ways including negative attitudes, false assumptions and behaviors reflecting ableist beliefs. Negative societal attitudes and beliefs about disability is strongly represented in literature (Bogart & Dunn, 2019; Kelly & Barnes-Holmes, 2013; Pruett & Chan, 2006; VanPuymbrouck et al., 2020) as is the way in which these attitudes and beliefs are conveyed to PWD in society (Kattari, 2020; Keller & Calgay, 2010; Olkin, 2019) and in therapy spaces (Conner et al., 2023; Hunt et al., 2006).

Participants described experiences where their disability was overemphasized as a contributing factor to their experiences. Asch (1946) discussed how impressions of people are often organized around a *central trait* which then minimizes the presence and influence of other straits. Similarly, Wright (1983) noted how a characteristic of disability led people to make typically negative inferences about people with disabilities in other areas. Participants (see, Nova, pp 66-67. and Anne, pp.65-66) discussed how their disability was often the central characteristic from which comments and treatment recommendations stemmed from.

Participants also reported experiences where the impact of their disability was inappropriately minimized reflecting a misstep on their therapists' part to appropriately consider how disability was contextually important. Participants described receiving comments about their behaviors (see Nova, p. 64) and their communication style (see Cat, pp. 64-65) and described adjusting their actions. While these adjustments in behavior were mandated by the environment, it also reflects how people with disabilities are skilled in creatively navigating and coping with marginalizing experiences. These characteristics reflect an important aspect of disability culture (Gill, 1995) which reflect the finely tuned skills that disabled individuals possess in both understanding and navigating interpersonal communication and interactions.

Role of salient social identities

Participants also described how the intersection of their salient social identities with their therapists' identities played a role in their therapeutic experiences. Many described a lack of empathy, emotional load of explaining and teaching identity-related issues, and barriers in communication. While sharing identities with therapists did not guarantee a strong therapeutic relationship, participants described how it bridged a gap in cultural competence regarding disability and racial and ethnic concerns. For Cat, working with an Autistic therapist allowed her to engage in therapy in an authentic way and for her disability-related concerns (e.g., sensory difficulties, burnout) to be validated while working with non-autistic therapists led to misconceptions and misunderstandings about her behavior. The phenomena of clients describing therapists who *get it* is reflected in previous research (Hunt et al., 2006) and add to other studies (Conner et al., 2023) supporting the necessity of the presence of awareness and education of identity-related issues. The APA's Guidelines for Assessment and Intervention for Persons with Disabilities (2022) and Multicultural Guidelines (2017) highlight how awareness of and education regarding disability and intersection identities (e.g., race, ethnicity, gender) is paramount in cross-cultural care. Given the low prevalence of disabled psychologists (6%), the likelihood of providing cross-cultural care is high and supports the ongoing calls for psychologists to prioritize disability awareness and education (APA, 2022).

Several participants discussed how an ideal therapist would share their racial and ethnic identities in addition to other values (e.g., awareness of systems of oppression) though expressed low confidence in finding such a clinician. In Eva's situation, linguistic diversity and the burden of communicating in her second language created additional barriers in therapy in that it often slowed down the pace of her sessions. Evidence supports these concerns. Estimates show that over 80% of psychologists are White (APA, 2022), and as of 2015, only 231 psychologists indicated ability to provide services in Spanish (APA, 2015).

Institutional and Environmental Imprint

A consistent theme in this study was the presence and impact of environmental and institutional barriers on participants pursuing and engaging in psychotherapy. Consistent with other literature (Conner et al., 2023; Hunt et al., 2006), participants described consistent experiences where their needs conflicted with environmental and institutional structures. Environmental barriers included lack of curb cuts and automatic doors, lack of privacy in medical treatment facilities, and lack of telehealth options for therapy. Institutionally, the time-limited nature of sessions, lack of telehealth options, and lack of knowledge regarding multiple disabilities (e.g., PTSD and ADHD) presented additional accessibility concerns. While the kinds of barriers PWD face will vary depending on the nature of their disability, these findings reflect how participants assumed the burden of inaccessibility and often resulted in participants trading off getting their needs met to remain engaged in care. Viewed through the lens of disability culture (Gill, 1995), these findings reflect the participants' resolve and determination in remaining engaged in care and ability to adapt to less-than-ideal situations.

Accommodating environments and institutional practices reflected the therapist's role in creating an accessible therapy space, whether intentionally or unintentionally. Flexible payment structures, telehealth options for treatment, and environmental elements such as fidget toys and objects to increase emotional regulation increased access and engagement for participants. It is worth noting that these results may be incomplete as most participants indicated participating in teletherapy either entirely or at various points of time in their lives.

Implications

The findings of the study hold important implications for the field of counseling psychology as well as the broader field of psychology. Within psychology, disability has historically been medicalized and approached from a deficit-base model that emphasizes individual impairment and focuses on a cure (Olkin, 1999; 2002; Olkin & Pledger, 2003). However, psychologists have extensively advocated for disability to be conceptualized as a matter of human diversity (Andrews, 2020; Bogart & Dunn, 2019; Dirth & Branscombe, 2018; Gill, 1995; Olkin, 2017; Wright, 1983), and non-disabled psychologists should actively consult their work to increase their awareness and knowledge. Looking to other subfields such as rehabilitation psychology would be beneficial in establishing a blueprint for how psychology as a whole can shift towards a more strengths-based approach by prioritizing identity development, oppressive symptoms, social justice perspectives, and the role of advocacy (Bogart & Dunn, 2019; Forber-Pratt et al., 2019).

Participants referenced both the presence and lack of awareness and education of therapists regarding disability-related issues suggesting an imbalance in how mental health professionals are exposed to disability-related issues in training, education, and professional development spaces. Furthermore, perpetuation of ableist beliefs and microaggressions with the therapy space point to a need for psychologists to increase their knowledge regarding how these beliefs permeate the therapy space (Conner et al., 2023; Olkin, 2023).

Development of a framework for disability competence within psychology is needed. While the APA Guidelines for Assessment and Intervention with Persons with Disabilities (2022) encourages psychologists and those in-training to explore disability and psychological practice from a variety of angles, these guidelines serve as suggestions for how psychologists conduct themselves and are considered aspirational. Movement towards including disability-related competence amongst other cultural competencies in the APA's Ethical Principles of Psychologists and Code of Conduct would display a strong commitment to disability competence. Research exploring practitioner's knowledge of disability identity development, among other disability-related competencies is needed and may shed light on gaps in knowledge.

Incorporating disability competence into education (i.e., curriculum) and training (e.g., APA accreditation standards for internship training sites) is an important step in ensuring that future psychologists are prepared for future work with people with disabilities. For example, Olkin's *Disability-Affirmative Therapy* (2017) and Andrew's *Disability as Diversity (2020)* should be considered foundational readings for psychologists in-training. Whether trainees are aware or not, they are likely working with people with disabilities and need to be equipped and skilled to handle this work.

The APA should prioritize its efforts to increase the diversity of the workforce and recruit future disabled psychologists. Historically, research has been conducted *on* the community but rarely has research been guided *by* the community. Currently, the prevalence of disabled professionals in psychology is low (APA, 2016) and not increasing at the rate of other professionals from diverse groups (Andrews & Lund, 2015). The presence of disabled psychologists contributes to the diversity of the field and makes the education, training, and education of other psychologists that much richer.

The participants in this study described positive experiences with strength-based therapeutic approaches grounded in flexibility, advocacy, and attention to disability-related concerns in a balanced way which align well with many of counseling psychology's values including prevention of harm perpetuated by systems of oppression, interpersonal and system-level-advocacy, and contextual and strengths-based approaches to well-being. Counseling psychologists and those in-training should increase their knowledge regarding how ableism (interpersonal, environmental/structural, institutional) impacts the lives of PWD as well as how disability uniquely intersects with other systems of oppression (e.g., ageism, racism, sexism, classism, etc.).

Counseling psychologists should also prioritize growing their knowledge on how advocacy can play a role both within the therapeutic context and what existing literature says about the needs of PWD (Conner et al., 2023; Hunt et al., 2006; Olkin, 2017). For example, counseling psychologists should assess how clinical spaces they are situated in are accessible and accommodating to people with disabilities. Clinicians should take proactive steps towards reducing barriers (e.g., consider offering teletherapy services and inspect potential clinic spaces for accessibility concerns).

Counseling psychologists should consult resources to build their knowledge about how disability intersects with other social identities. Scholarship exploring the experience of disability within the Black/African American (Alston et al., 1996; Bailey & Mobley, 2019; Belgrave, 1998; Belgrave & Jarma, 2000; Gray, Ndukwe, & Kuemmel, 2022) and Latinx communities (Lavín et al., 2024; García & Zea, 1997; Zea et al., 1997) hold important implications for how cultural and sociopolitical influences impact the experience of disability.

With scholarship on disability-related concerns in counseling psychology remaining low (Foley-Nicpon & Lee, 2012), prioritizing the disability community in future research is of upmost importance. Approaches including DA-T (Olkin, 2017) and disability culture (Gill, 1995) align well with the findings of this study, and future research should focus on exploring the application of these approaches in clinical spaces. Scholars should focus on situating disability culture within broader multicultural frameworks and explore strengths-based approaches to clinical care. Given how the participants in this study were predominantly White, cisgender women, future research should explore the psychotherapy experiences of men, ethnic and racial minorities (e.g., Black/African descent and Latinx individuals), and LGBTQ+.

Limitations

All participants in this study either held a doctoral degree in psychology or were working towards a doctorate in a psychology-related field. Thus, it's possible that insider knowledge of psychotherapy process influenced the findings of these results. Despite diverse identities being represented in this study, the findings and implications of this study are limited by the sample. First, the majority of participants were cisgender, White women. Thus, these findings do not capture the experiences of disabled men in psychotherapy. Research on men, including men from ethnically diverse groups, and disability remains lacking and future studies should make considerable efforts to explore this perspective. While race and ethnicity were discussed by participants in this study, interview questions did not explicitly explore how disability and race and ethnicity uniquely impacted the participant's experiences. Additionally, other intersecting identities including socioeconomic status, religion, education level, and age were not explored. The oldest participant was 48, and thus the experiences of older adults with disabilities were not captured.

While this study included a diverse range of disabilities compared to previous studies, there were many types of disabilities not represented. Individuals selected many categories for their disabilities including psychological/emotional. However, only one of the participants discussed their psychological/emotional disability. Psychological and emotional disabilities remain an understudied area and the results of this study are limited by the lack of exploration in this area. Finally, only data regarding participants' experiences in individual therapy were included in the study despite most participants discussing experiences with other mental health treatment (e.g., group therapy, psychiatric hospitalization, and medication management). Thus, these findings are limited by the narrow focus on individual therapy, and future research should expand on broader experiences in mental health care.

Closing Thoughts

Hearing the participants' stories and getting to share in their vulnerability is an experience I will treasure. In many ways, this study has brought me back home and rooted me in an unexpected yet much needed way. It has reconnected me with the values of counseling psychology and why I love the work that I do. It has reconnected me with why it is important to understand the struggles and the joy of others. There were many moments throughout this study where I was immersed in the ways in which the sociopolitical context deeply impacted the participants, and it was difficult to not feel discouraged. Re-familiarizing myself with the tenets of disability culture reminded me of the importance of not forgetting the joy, creativity, flexibility, determination, skill in dealing with uncertainty, and resolve that the disability culture espouses.

There were numerous moments where I faced my own fears, doubts, and intense moments of uncertainty. For years I have longed to do this study, and I deeply wanted to do these participants justice by capturing their stories in an authentic and meaningful way. Throughout data collection and analysis, I often felt as though I needed to prove that I knew what I was doing – with my participants and with my research team. However, my goal in navigating this study was to remain authentic in who I was which meant often telling my team “We’ll figure this out together.” Qualitative research is not for the faint of heart. I truly learned what iterative and recursive mean. Anytime I found myself stuck in the coding process or I was unsure of the themes I was generating, I returned back to the participants stories, and asked myself, what is it that they are telling me here?

If I had the opportunity to do this study again, I would add disability culture (Gill, 1995) as a framework to guide my approach to interviewing and to guide data analysis. While this study was exploratory in nature, I believe that adding the cultural layer may produce new meaning to the participants’ experiences that have yet to unfold in literature. Reflecting back, I am also curious about the stages of disability identity development of each participant. I would add a measure that assessed each participant’s disability identity as an additional way to understand the participants’ stories.

I know that I am not the first psychologist in-training to desire a psychological field that views disability as a matter of human diversity and for disabled people to seen in a holistic way. Throughout this study, I was reminded of the strong band of psychologists who have worked for decades to advance the field, and I am grateful to join them. My hope is that this research will help shift the way we understand psychological work with the disabled community and will spur future scholars to prioritize centering the experiences and stories of the disability community.

References

Alston, R. J., Bell, T. J., & Feist-Price, S. (1996). Racial identity and African Americans with disabilities: theoretical and practical considerations. *The Journal of Rehabilitation*, *62*(2), 11. https://link.gale.com/apps/doc/A18534471/AONE?u=anon~9995869f&sid=googleScholar&xid=06873540

Andrews, E.E. (2020). *Disability as diversity: developing cultural competence*. Oxford University Press.

Andrews, E.E., & Lund, E.M. (2015). Disability in psychology training: Where are we? *Training and Education in Professional Psychology*, *9*(3), 210-216. https://doi.org/10.1037/tep0000085

American Academy of Physical Medicine and Rehabilitation. (2022). *PASC Dashboard: Post-Acute Sequelae of SARS-CoV-2 Infection (PASC) Estimates and Insights* (Updated September 12, 2022). Retrieved, September 13, 2022, from https://pascdashboard.aapmr.org/

American Psychological Association (1984). Task force on psychology and the handicapped. *American Psychologist, 39,* 545-550.

American Psychological Association (2016). *2015 survey of psychology health service providers*. Washington, DC: Author.

American Psychological Association. 2017. *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality*. http://www.apa.org/about/policy/multicultural-guidelines.pdf

American Psychological Association. (2022). Demographics of U.S. Psychology Workforce [interactive data tool]. Retrieved [May 5, 2024], from https://www.apa.org/workforce/data-tools/demographics

American Psychological Association, APA Task Force on Guidelines for Assessment and Intervention with Persons with Disabilities. (2022). *Guidelines for Assessment and Intervention with Persons with Disabilities*. https://www.apa.org/about/policy/guidelines-assessment-intervention-disabilities.pdf

American With Disabilities Act of 1990, Public Law 101-336, 42 U.S.C. 12111, 12112.

Asch, A. (1946). Forming impressions of personality. *Journal of Abnormal and Social Psychology, 41*, 258-290.

Bailey, M., & Mobley, I.A. (2019). Work in the intersections: A black feminist disability framework. *Gender & Society, 33*(1), 19-40.

Bevan, M. (2014). A method of phenomenological interviewing. *Qualitative Health Research, 24*(1), 136-144. https://doi.org/10.1177/1049732313519710

Belgrave, F.Z. (1998). *Psychosocial aspects of chronic illness and disability among African Americans*. Santa Barbara, CA: Greenwood Publishing Group.

Belgrave, F.Z., & Jarma, S.L. (2000). Culture and disability in the rehabilitation experience: An African American example. In R.G. Frank & T.R. Elliott (Eds.), *Handbook of rehabilitation psychology* (pp. 585-600). Washington, DC: American Psychological Association.

Bogart, K. R., & Dunn, D. S. (2019). Ableism special issue introduction. *Journal of Social Issues, 75*(3), 650-664. https://doi.org/10.1111/josi.12354

Braun, V. (2022). *Thematic Analysis: a practical guide* (V. (Associate P. in S.S. Clarke (Ed.)). SAGE.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise, and Health*, *11*(4). 589-597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2019b). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health, 13,* 1-16. https://doi.org/10.1080/2159676X.2019.1704846

Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2019). Thematic Analysis. In P. Liamputtong (Ed.), *Handbook of Research Methods in Health and Social Sciences* (pp.843-860). Springer Singapore.

Braun, V., Clarke., V, & Weate, P. (2017). Using thematic analysis in sport and exercise research. In B. Smith and A.C. Sparkes (Eds.), *Routledge Handbook of Qualitative Research in Sport and Exercise* (pp.191-205). Routledge London.

Brownridge, D.A. (2006). Partner violence against women with disabilities: Prevalence, risk, and explanations. *Violence Against Women, 12*(9), 805-822.

Byrne, D. (2021). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality and Quantity, 56*(3), 1391. https://doi.org/10.1007/s11135-021-01182-y

Campbell, J., Gilmore, L., & Cuskelly, M. (2003). Changing student teachers' attitudes towards disability and inclusion. *Journal of Intellectual and Developmental Disability, 28*(4), 369-379.

Cencirulo, J., McDougall, T., Sorenson, C., Crosby, S., & Hauser, P. (2021). Trainee experiences of racism, sexism, heterosexism, and ableism (the "ISMs") at a Department of Veterans

Affairs (VA) healthcare facility. *Training and Education in Professional Psychology*, *15*, 242-249. https://doi.org/10.1037/tep0000312

Center for Disease Control and Prevention, National Center for Health Statistics. (2022a). *Long Covid: Household Pulse Survey*. https://www.cdc.gov/nchs/covid19/pulse/long-covid.htm

Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disability. (2022b). *Disability and Health Data System (DHDS) [online]*. Retrieved from https://www.cdc.gov/ncbddd/disabilityandhealth/dhds/index.html

Charlton, J. I. (1998). *Nothing about us without us; Disability oppression and empowerment* (1st ed.). University of California Press.

Cochran, A. L. (2020). Impacts of COVID-19 on access to transportation for people with disabilities. *Transportation Research Interdisciplinary Perspectives*, *8*. https://doi.org/10.1016/j.trip.2020.100263

Creswell, J. W., & Creswell, J. W. (2007). *Qualitative inquiry & research design: choosing among five approaches* (Second edition.). Sage Publications.

Crow, L. (1996). Including all of our lives: Renewing the social model of disability. In J. Morris (Ed.), *Encounters with strangers: Feminism and disability* (pp. 206-226). Women's Press.

Deroche, M. D., Herlihy, B., & Lyons, M. L. (2020). Counselor trainee self-perceived disability competence: Implications for training. *Counselor Education and Supervision, 59*(3), 187-199. https://doi.org/10.1002/ceas.12183

Dirth, T.P., & Branscombe, N.R. (2018). The social identity approach to disability: Bridging disability studies and psychological science. *Psychological Bulletin, 144*(12), 1300-1324. https://doi.org/10.1037/bul0000156

Dovidio, J. F., Pagotto, L., & Hebl, M. R. (2011). Implicit attitudes and discrimination against people with physical disabilities. In R. L. Wiener & S. L. Willborn (Eds.), *Disability and aging discrimination: Perspectives in law and psychology* (pp. 157-183). Springer Science + Business Media. https://doi.org/10.1007/978-1-4419-6293-5_9

Driedger, D. (1989). *The Last Civil Rights Movement: Disabled Peoples' International*. St. Martin's Press.

Dunn, D. S., & Andrews, E. E. (2015). Person-first and identity-first language. *The American Psychologist, 70*(3), 255-264. https://doi.org/10.1037/a0038636

Evans, L., & Randle-Phillips, C. (2020). People with intellectual disabilities' experiences of psychological therapy: A systematic review and meta-ethnography. *Journal of Intellectual Disabilities, 24*(2), 233-252. http://dx.doi.org/10.1177/1744629518784359

Fitchen, C. S., & Amsel, R. (1986). Trait attributions about college students with a physical disability: Circumplex analyses and methodological issues. *Journal of Applied Social Psychology, 16*(5), 410-427.

Foley-Nicpon, M., & Lee, S. (2012). Disability research in counseling psychology journals: A 20-year content analysis. *Journal of Counseling Psychology, 59*(3), 392-398. https://doi.org/10.1037/a0028743

Freeman, M. (2021). Five threats to phenomenology's distinctiveness. *Qualitative Inquiry, 27*(2), 276-282. https://doi.org/10.1177/1077800420912799

Forber-Pratt, A. J., Mueller, C. O., & Andrews, E. E. (2019). Disability identity and allyship in rehabilitation psychology: Sit, stand, sign, and show up. *Rehabilitation Psychology, 64*(2), 119–129. https://doi.org/10.1037/rep0000256

Friedman, C. (2019). Mapping ableism: A two-dimension model of explicit and implicit disability attitudes. *Canadian Journal of Disability Studies, 8,* 95-120. https://doi.org/10.15353/cjds.v8i3.509

García, J. G., & Zea, M. C. (Eds.). (1997). *Psychological interventions and research with Latino populations.* Allyn & Bacon.

Gill, C.J. (1994). A bicultural framework for understanding disability. *Family Psychologist, 10,* 13-16.

Gill, C.J. (1995). A psychological view of disability culture. *Disability Studies Quarterly, 15*(4), 16-19.

Gill, C.J. (1996). Dating and relationship issues. *Sexuality and Disability, 14*(3), 183-190.

Gill, C.J. (1997). Four types of integration in disability identity development. *Journal of Vocational Rehabilitation, 9*(1), 39-46.

Gilson, S.F. Tusler, Tusler, A., & Gill, C. (1997). Ethnographic research in disability identity: phneSelf-determination and community. *Journal of Vocational Rehabilitation, 9*(1) 7-17.

Goodley, D., & Lawthom, R. (2006). Disability studies and psychology: New allies? In D. Goodley and R. Lawthom (Eds.), *Disability and psychology: Critical introductions and reflections* (pp.1-16). Palgrave Macmillan

Grant, C. A., & Zwier, E. (2011). Intersectionality and student Outcomes: Sharpening the struggle against racism, sexism, classism, ableism, heterosexism, nationalism, and linguistic, religious, and geographical discrimination in teaching and learning. *Multicultural Perspectives, 13*(4), 181-188. https://doi.org/10.1080/15210960.2011.616813

Gray, A. A., Ndukwe, N., & Kuemmel, A. M. (2022). African American women with disabilities. In K. Shelton, M. K. Lyn, & M. Endale (Eds.), *A handbook on counseling*

African American women: Psychological symptoms, treatments, and case studies (pp. 247–266). Praeger/ABC-CLIO.

Haegele, J. A., & Hodge, S. (2016). Disability discourse: Overview and critiques of the medical and social models. *QUEST, 68*(2), 193-206. https://doi.org/10.1080/00336297.2016.1143849

Hays, D. G., & Singh, A. A. (2012). *Qualitative Inquiry in Clinical and Educational Settings*. The Guilford Press.

Hogben, M., & Waterman, C. K. (1997). Are all of your students represented in their textbooks: A content analysis of coverage of diversity issues in introductory psychology textbooks. *Teaching of Psychology*, *24*(2), 95–100.

Hostyn, I., & Maes, B. (2009). Interaction between persons with profound intellectual and multiple disabilities and their partners: A literature review. *Journal of Intellectual and Developmental Disability*, *34*(4), 296-312.

Hunt, B., Matthews, C., Milsom, A., & Lammel, J. A. (2006). Lesbians with physical disabilities: A qualitative study of their experiences with counseling. *Journal of Counseling & Development, 84*, 163-173. https://doi.org/10.1002/j.1556-6678.2006.tb00392.x

Kamalakannan, S., Bhattacharjya, S., Bogdanova, Y., Papadimitriou, C., Arango-Lasprilla, J. C., Bentley, J., Jesus, T. S., & Refugee Empowerment Task Force International Networking Group Of The American Congress Of Rehabilitation Medicine. (2021). Health risks and consequences of a COVID-19 infection for people with disabilities: Scoping review and descriptive thematic analysis. *International Journal of Environmental Research and Public Health*, *18*(8). https://doi.org/10.3390/ijerph18084348

Kattari, S. K. (2020). Ableist microaggressions and the mental health of disabled adults. *Community Mental Health Journal, 56*(6), 1170-1179. https://doi.org/10.1007/s10597-020-00615-6

Keller, R. M., & Galgay, C. E. (2010). Microaggressive experiences of people with disabilities. In D.W. Sue (Ed.), *Microaggressions and marginality: Manifestation, dynamics, and impact.* (pp. 241-267). John Wiley & Sons Inc.

Kelly, A., & Barnes-Holmes, D. (2013). Implicit attitudes towards children with autism versus normally developing children as predictors of professional burnout and psychopathology. *Research in Developmental Disabilities, 34*(1), 17–28. https://doi.org/10.1016/j.ridd.2012.07.018

Kemp, N. T., & Mallinckrodt, B. (1996). Impact of professional training on case conceptualization of clients with a disability. *Professional Psychology Research and Practice*, *27*(4), 378–385

Kendall, E., Ehrlich, C., Chapman, K., Shirota, C., Allen, G., Gall, A., Kek-Pamenter, J., Cocks, K., & Palipana, D. (2020). Immediate and long-term implications of the COVID-19 pandemic for people with disabilities. *American Journal of Public Health (1971), 110*(12), 1774-1779. https://doi.org/10.2105/AJPH.2020.305890

Langdridge, D. (2004). *Introduction to research methods and data analysis in psychology*. Pearson/Prentice Hall.

Lavín, C. E., & Francis, G. L. (2024). Looking in the Shadows: Literature on Undocumented Latinx Students with Disabilities. *Journal of Latinos and Education*, *23*(1), 424–437. https://doi.org/10.1080/15348431.2022.2149529

Lund, E. M., & Ayers, K. B. (2020). Raising awareness of disabled lives and health care rationing during the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*(S1), S201-211. https://doi.org/10.1037/tra0000673

Lund, E. M., Forber-Pratt, A. J., Wilson, C., & Mona, L. R. (2020). The COVID-19 pandemic, stress, and trauma in the disability community: A call to action. *Rehabilitation Psychology, 65*(4), 313-322. https://doi.org/10.1037/rep0000368

Morrow, S. L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *Counseling Psychologist, 35*(2), 209-235. http://dx.doi.org/10.1177/0011000006286990

National Council on Disability (2021). *Impact of COVID-19 on people with disabilities*. https://ncd.gov/sites/default/files/NCD_COVID-19_Progress_Report_508.pdf

Olkin, R. (1999). *What psychotherapists should know about disability*. Guilford Press.

Olkin, R. (2002). Could you hold the door for me? Including disability in diversity. *Cultural Diversity & Ethnic Minority Psychology*, *8*(2), 130-137. https://doi.org/10.1037/1099-9809.8.2.130

Olkin, R. (2017). *Disability-affirmative therapy: A case formulation template for clients with disabilities.* Oxford University Press.

Olkin, R., Hayward, H., Abbene, M. S., & VanHeel, G. (2019). The experiences of microaggressions against women with visible and invisible disabilities. *Journal of Social Issues, 75*(3), 757-785. https://doi.org/10.1111/josi.12342

Olkin, R., & Pledger, C. (2003). Can disability studies and psychology join hands? *The American Psychologist, 58*(4), 296-304. https://doi.org/10.1037/0003-066X.58.4.296

Parritt, S., & O’Callaghan, J. (2000). Splitting the difference: An exploratory study of therapists' work with sexuality, relationships and disability. *Sexual and Relationship Therapy, 15*(2), 151-169. https://doi.org/10.1080/14681990050010745

Penrose, W.D. (2015). The discourse on disability in ancient Greece. *The Classical World, 108*(4). 499-523.

Polkinghorne, D.E. (1989). Phenomenological research methods. In R.S. Valle and S. Halling (Eds.), *Existential-Phenomenological perspectives in psychology: Exploring the breadth of human experience* (pp. 41-60). Plenum Press.

Pruett, S.R., & Chan, F. (2006. The development and psychometric validation of the Disability Attitude Implicit Association Test. *Rehabilitation Psychology, 51*, 202-213.

Pulrang, A. (2020, August 31). *A simple fix for one of disabled people’s most persistent, pointless injustices*. Forbes. https://www.forbes.com/sites/andrewpulrang/2020/08/31/a-simple-fix-for-one-of-disabled-peoples-most-persistent-pointless-injustices/?sh=cc534156b71f

Pulrang, A. (2022, March 31). *What’s next in ‘marriage equality’ for people with disabilities?.* Forbes. https://www.forbes.com/sites/andrewpulrang/2022/03/31/whats-next-in-marriage-equality-for-people-with-disabilities/?sh=182d48d86eb7

Rajkumar, S. (2022, July 14). *Many try to return to normal from COVID, but disabled people face a different reality*. NPR. https://www.npr.org/2022/07/14/1109874420/covid-safety-disabled-people-immunocompromised

Reber, L., Kreschmer, J.M., James, T.G., Junior, J.D., DeShong, G.L., Parker, S. & Meade, M.A. (2022). Ableism and contours of the attitudinal environment as identified by adults with long-term physical disabilities: a qualitative study. *International Journal of Environmental Research and Public Health, 19*(12). 7469.

Risdal, D., & Singer, G.H. (2004). Martial adjustment in parents of children with disabilities: A historical review and meta-analysis. *Research and Practice of Persons with Severe Disabilities, 29*(2), 95-103.

Rivas, M. (2020). Disability in counselor education: Perspectives from the United States. *International Journal for the Advancement of Counselling, 42*(4), 366-381. https://doi.org/10.1007/s10447-020-09404-y

Rivas, M., & Hill, N. R. (2018). Counselor trainees' experiences counseling disability: A phenomenological study. *Counselor Education and Supervision, 57*(2), 116-131. https://doi.org/10.1002/ceas.12097

Rosa, N. M., Bogart, K. R., Bonnett, A. K., Estill, M. C., & Colton, C. E. (2016). Teaching about disability in psychology. *Teaching of Psychology, 43*(1), 59-62. https://doi.org/10.1177/0098628315620885

Shakespeare, T., Ndagire, F., & Seketi, Q.E. (2021). Triple jeopardy: Disabled people and the COVID-19 pandemic. *Lancet,* 397(10282), 1331-1333. https://doi.org/10.1016/S0140-6736(21)00625-5

Smith, L., Foley, P. F., & Chaney, M. P. (2008). Addressing classism, ableism, and heterosexism in counselor education. *Journal of Counseling & Development, 86,* 303-309. https://doi.org/10.1002/j.1556-6678.2008.tb00513.x

Smith, M. P. (2022). Estimating total morbidity burden of COVID-19: Relative importance of death and disability. *Journal of Clinical Epidemiology, 142,* 54-59 https://doi.org/10.1016/j.jclinepi.2021.10.018

Stead Sellers, F. (2022, July 23). Long covid could change the way we think about disability. *The Washington Post*. https://www.washingtonpost.com/

Sue, D.W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. John Wiley & Sons.

Swain, J., Griffiths, C., & Heyman, B. (2003). Towards a social model approach to counselling disabled clients. *British Journal of Guidance & Counselling, 31*(1), 137-152. https://doi.org/10.1080/0306988031000086215

Tong, A., & Craig, J. (2019). Reporting of Qualitative Health Research. In P. Liamputtong (Ed.), *Handbook of Research Methods in Health and Social Sciences* (pp. 971-984). Springer Singapore.

Vagle, M. D. (2018). *Crafting phenomenological research*. Routledge. https://doi.org/10.4324/9781315173474

VanPuymbrouck, L., Friedman, C., & Feldner, H. (2020). Explicit and implicit disability attitudes of healthcare providers. *Rehabilitation Psychology, 65*, 101-112. https://doi.org/10.1037/rep0000317

Whitesel, J. (2017). Intersections of multiple oppressions: racism, sizeism, ableism, and the “illimitable etceteras” in encounters with law enforcement, *Sociological Forum, 32*(2), 426-433. https://doi.org/10.1111/socf.12337

World Health Organization. (2021, November 24). *Disability and health*. https://www.who.int/news-room/fact-sheets/detail/disability-and-health

Wilson, M. C., & Scior, K. (2014). Attitudes towards individuals with disabilities as measured by the Implicit Association Test: A literature review. *Research in Developmental Disabilities, 35*(2), 294-321. https://doi.org/10.1016/j.ridd.2013.11.003

Wright, B.A. (1983). *Physical disability: A psychosocial approach* (2nded.). New York: Harper & Row.

Zea, M. C., Belgrave, F. Z., García, J. G., & Quezada, T. (1997). Socioeconomic and cultural factors in rehabilitation of Latinos with disabilities. In J. G. García & M. C. Zea (Eds.), *Psychological interventions and research with Latino populations* (pp. 217–234). Allyn & Bacon.

APPENDIX A

Demographic Form

Please provide an email address and phone number to be contacted regarding the study (your email or phone number will not be shared).

Please select the category that best describes your disability/disabilities. If you live with multiple disabilities, please select all that apply:

○ Mobility/Physical
○ Spinal Cord (SCI)
○ Acquired brain injury
○ Neurological disorder
○ Blind or low vision
○ Deaf or Hard of Hearing
○ Cognitive/Intellectual Disability
○ Psychological/Emotional/Mental Illness
○ Chronic Illness (e.g., chronic pain, long covid, diabetes, etc.)
○ Neurodivergent
○ Other Disability Category (please specify)

Do you identify as a person living with multiple disabilities?

○ Yes
    Please describe the nature of each disability.
○ No

Please select the nature of onset of your disability (select all that apply):

○ Congenital (present at birth)
○ Developmental
○ Acquired
○ Temporary

Please select the nature of your disability:

○ Acute
○ Chronic
○ Other (please specify)

What is your age?

Although the categories listed below may not represent your full identity or use the language you prefer, for the purpose of this survey, please indicate which group below most accurately describes your racial identification.
○ Alaskan Native/ Native American/ Indigenous
○ Asian
○ Black
○ Latino(a)/ Hispanic (Non-White)
○ Latino (a)/ Hispanic (White)
○ Pacific Islander/ Native Hawaiian
○ White
○ Multiracial (please specify)
○ Other Racial Identity (please specify)

Ethnicity or ethnic culture refers to patterns of ideas and practices associated with a group of people sharing a common history, geographic background, and/or language, rather than their racial background. In your own words, what is your ethnic identification(s)?
Open text:____

Please specify your gender identity.

What is your sex?

Please specify your sexual orientation.

Please describe accommodations needed to make the interview accessible for you:

APPENDIX B

Interview Protocol

Psychotherapy Experiences of People Living with Disabilities

Interviewee (pseudonym): Date: Start time: End Time:

Hi, (pseudonym). My name is Denise Powers, and I am a doctoral student in the Counseling Psychology program at the University of Georgia. I am conducting my dissertation study on the psychotherapy experiences of people living with disabilities, and I am interested in learning more about your experiences as a disabled person receiving psychotherapy treatment. As a disabled person, you offer a unique perspective on psychotherapy treatment, and I greatly appreciate the time you are taking today to talk to me about your experiences.

Before we begin today, there are a couple of reminders regarding the privacy and confidentiality of the information you will share with me today. All information you share will be kept confidential, and I will not use your name or any identifying information such that someone may be able to figure out who you are. Additionally, your participation in this interview is entirely voluntary, and you can skip any questions that you do not want to answer as well as end the interview at any time. I anticipate that the interview will most likely last between 60 and 90 minutes. You are also welcome to ask me any questions you may have throughout the interview. Are there any questions I can answer before we begin?

Discussion of accommodations (if applicable): As discussed previously, ___________________ (will acknowledge previously discussed accommodations and how the interview will be tailored to meet their accommodations).

Questions to Build Rapport:

1. Is there anything that would be helpful for me as the interviewer to know before we start discussing your experiences being in counseling or therapy?
2. What is your preference for the kind of language I use when referring to your disability?

Research Question 1

What are the experiences of people with disabilities in individual therapy settings?

3. Can you describe to me about pursuing psychotherapy as a person with (*insert preferred language for participants specific disability or disabilities*)?

   Probing questions: Was (*insert preferred language for participants specific disability or disabilities*) related to your reason for pursuing psychotherapy at any point? Did your experiences with (*insert preferred language for participants specific disability or disabilities*) emerge during the course of your treatment?

4. Describe to me receiving counseling as a person living with ___ (*insert preferred language for participants specific disability or disabilities*):

   Probing questions: How old were you when you first started counseling? How many different mental health clinicians have you worked with?

5. Describe to me your experiences working with each mental health provider (if you worked with multiple providers).

   Probing Questions: How long (approximate number of sessions or length of time) did you work with each clinician? What were the demographics of each therapist that you worked with? You mentioned ____, can you please describe what you mean by ____. Describe how your counseling experience would change if ____ (building off data provided by participants).

6. Can you describe to me your experiences with the physical environment of the counseling spaces where you received/engaged in treatment?

   Probing Questions: (using imaginative variation) Describe how your psychotherapy experience would change if ________ (building off participants' response to initial question).

Research Question 2

What, if any, is the essence of counseling that people with disabilities perceive and describe as helpful?

7. Can you describe for me your psychotherapy experiences as someone living with _____ (*insert preferred language for participants specific disability or disabilities*) that you felt were helpful or beneficial for you?

Research Question 3

What, if any, is the essence of counseling that people with disabilities perceive and describe as unhelpful?

8. Can you describe for me your psychotherapy experiences as someone living with _____ (*insert preferred language for participants specific disability or disabilities*) that you felt were unhelpful or negative?
9. Describe to me how your psychotherapy experiences would change if ____ (building off of the answer to previous question).

Final Question: I have asked you many questions today, and I wanted to provide you the opportunity to share with me anything else that you would like to add. Is there anything you would like for me to know about your psychotherapy experiences as a person living with a disability?

Wrap-up: I want to thank you for sharing your experiences with me. I am grateful for the time you shared with me today. If I have any follow-up questions after today, is it okay if I contact you again?