DISABILITIES

Physical disability and the therapeutic relationship

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Published on 17th November, 2022

Partway through my undergraduate degree, I became unwell, was diagnosed with a chronic illness, and now find myself with impaired mobility. I began to wonder how, having had life so irrevocably changed, would I ever be able to qualify as a counsellor, and what is it like for disabled clients seeking therapy from a predominantly able-bodied profession?

It is estimated that between 10-12% of the world population suffer from a physical disability of some sort, but, while there has been considerable research into the psychological issues experienced by this group, there appears to have been little exploration into the phenomenology of disabled clients or their therapists. It is widely

acknowledged that no matter its severity, an acquired disability will disrupt normality, unsettling the individual's social, professional, and family life.

The impact of losing one's identity and independence is tremendous but potentially misunderstood. While you might well imagine that the disabled person will undergo a process of mourning, experiencing grief, denial and anger, these perceived losses only come from the imagination of the able-bodied. This 'individual tragedy' perspective stems from the assumption that the impairment is the cause of disability rather than seeing the environment as the disabling factor.

In her 2004 article, '*Oppression within the counselling room*', Donna Reeve asserts that disability is a social construct and that the source of emotional distress comes from the failure of society to consider the needs of the mobility impaired, suggesting also, that the removal of environmental challenges would leave the physically impaired person with no more in need of counselling than anyone else.

But, by offering disabled clients alternatives such as online or telephone counselling, or by changing the venue, we are perhaps only serving to remind the client that they are different and out of place, an issue potentially exasperated by the low numbers of physically disabled counsellors in practice. Of course, it could be argued that blaming the environment fundamentally reduces the disabled individual's experience to that of an oppressed minority, and that it also fails to address the fundamental problem of unconscious attitudes to, and perception of, disability and the disabled.

My Rogerian training tells me that I should see any disability simply as part of the human condition, the focus of the therapy being dictated by the client. However, it ignores two fundamental facts: first, that it is potentially damaging to ignore a disability that a client may have incorporated into their identity; and secondly, that as a therapist I must not only understand my own unconscious bias', but also the client's own perceptions and beliefs around their disability.

So, should I acknowledge the client's, or my own, disability within the therapy room? It seems to me that the only people who have the experience to truly know are the disabled/chronically ill clients and therapists themselves, leaving me with the

question of whether physical disability or chronic illness could interfere with the therapeutic relationship?

While studying the literature on this subject I have come to the belief that any progress that has been made towards multiculturalism within society certainly does not extend to disability. It is, of course, impossible and wrong, to make sweeping statements. However, in my reading about this subject, I have come across some disturbing reports where disabled clients tell of the deplorable attitudes they have experienced from counsellors. One recalls how a psychologist could not make the link between frustration and the client's impairment. Another describes how a counsellor refused to engage with the client as a disabled person, grudgingly moving furniture to accommodate a wheelchair. For me personally, the most shocking is the recounting of one client who described how the therapist's attitude implied that "they were going to be seeing a total vegetable"!

But negative bias flows in both directions... while there are those who consider that disabled counsellors are in some way inadequate and that disability must interfere with the therapeutic relationship, there will be others who consider that disabled counsellors may be more empathic and display more unconditional positive regard and genuineness than their able-bodied counterparts. While one disabled person may assume an able-bodied counsellor is yet another professional who will try to cure their disability through psychological change, another might choose a non-disabled counsellor because of an internalised belief that a disabled counsellor will not be competent.

Regardless of modality, it is widely accepted that a good therapeutic relationship is fundamental to meaningful therapy, but negative attitudes, beliefs, and associations may inadvertently contribute to the perceptions of the physical disabilities as diseased, broken, and in need of fixing, which in turn could negatively impact the counselling relationship. What is clear is that the model of disability that a therapist subscribes to has a considerable impact on how they view their clients.

For example, the moral model views disability as a personal tragedy, the reasons why are not to be understood, it is simply accepted as God's will. A therapist viewing their client in this way is hazardous for the therapeutic relationship; by defining a person's

life as tragic, feelings of sympathy are evoked, potentially isolating, and alienating the client, even though some people with disabilities strongly identify with this model.

In contrast, the medical model portrays disability as a medical error within the person's physiology or psychology, which prevents them from having full functionality. This limited view can also be detrimental to the therapeutic relationship, as seeing the client as 'other', potentially blocks empathy and suggests that they are physically, mentally, and emotionally, dysfunctional.

Both moral and medical models are juxtaposed against the humanistic disability-affirmative model's core assumption that the client's disability is information-enhancing the case conceptualisation. A healthy therapeutic relationship can only exist if the partnership is one of equality and acceptance that the disabled person can reach their full potential, whatever that may be, and removes the imbalance of power within the client-therapist relationship.

Undoubtedly a disabled therapist/able-bodied client relationship must be influenced by the nature and origin of the therapist's condition, with clients' reactions ranging from curiosity to anxiety, suggesting that early disclosure by the disabled therapist is imperative.

In a recent Webinar, '*Working as a counsellor with a chronic condition*', one online therapist described how, as their chronic pain condition deteriorated, it became impossible to hide from clients, especially as surgery was involved. At disclosure, the majority of their clients expressed relief as they had known something was clearly wrong, and had felt concerned, but had been uncomfortable asking about it.

My own disability and whether or not to disclose, or how much to disclose, was rather a moot point in my training placement as I met my clients at reception on a mobility scooter. If clients asked me not to accompany them back to reception at the end of our sessions, it was something I agreed to simply because it seemed to empower them. I am sure some would disagree with my approach, but I did what felt right at the time. However, particular care must be taken that disclosure does not cause clients to downplay their own issues as trivial or detract from the client's needs, especially in crisis.

Another potential barrier to the therapeutic relationship is the lack of awareness an able-bodied counsellor may have of the specific issues relating to physical disabilities/chronic illness. While the majority of disabled clients will find counselling to be beneficial, many report that mainstream counsellors have little, or no, comprehension of their difficulties. While some barriers may be obvious (the stairs leading into the building) some cannot be seen or are hard to understand, but counsellors must accept them as reality. Understanding the historical attitudes that underpin our perceptions and influence the terminology we use in relation to disability is really important.

It is the language we use, regardless of our intention, that has the power to either support or demean and what communicates our attitudes about others. When working with the disabled, it is important to be aware of terminology that may promote negative perceptions, including phrases like 'invalid', 'suffering', 'afflicted', 'victim', 'handicapped', 'crippled', and 'wheelchair-bound'.

As with any minority group, some people living with a disability have preferred terminology for identifying themselves. As people with disabilities become empowered and are less inclined to accept that ‘the professionals know best’ the counsellor must educate themselves before a beneficial therapeutic relationship can develop.

It is vital for therapists to understand that, regardless of the nature of their disability, individuals face environmental, accessibility, health, political, employment and attitudinal obstacles all the time. The failure to consider physical barriers, such as steps or furniture, before the client’s arrival simply adds to the psycho-emotional oppression suffered by the disabled.

Given that depression is three times more likely for the disabled than their able-bodied counterparts, it should be surprising that there is no emphasis on this in our training or much in the way of specialist CPD courses. I do not believe that counselling can, in any way, repair the ‘problem’ of disability because it isn’t of the individuals making, but what counselling can do is walk beside someone as they explore how society disables them and the associated emotions. It is to this end that I believe training providers, especially those accredited by professional bodies,

should be incorporating disability equality training into undergraduate and post-graduate training programmes.

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