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## Social workers' changing perceptions of disability through working with clients with disabilities

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Juliette Kennedy  
Social Workers' Changing  
Perceptions of Disability  
Through Working with Clients  
With Disabilities

## **ABSTRACT**

This qualitative study explores the changing perceptions (attitudes and language use) of clinical social workers toward clients with disabilities through a qualitative exploration of clinicians' experiences working with this population over time. Based upon in-depth semi-structured interviews with nine experienced clinical social workers currently in private practice, the findings suggest that clinicians' attitudes and language use toward persons with disabilities are influenced by many factors, including contact with individuals with disabilities, supervision, post-masters training and social work theory. While participants in this study were not versed in disability theory, they nonetheless were flexible in applying alternative approaches with their clients with disabilities and approaches changed over time as the client's needs changed. The results of this study have several implications for education and social work practice with clients with disabilities.

SOCIAL WORKERS' CHANGING PERCEPTIONS  
OF DISABILITY THROUGH WORKING WITH CLIENTS  
WITH DISABILITIES

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2012

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## TABLE OF CONTENTS

ACKNOWLEDGEMENTS .....	ii
TABLE OF CONTENTS.....	iii
LIST OF TABLES .....	iv
CHAPTER	
I INTRODUCTION .....	1
II LITERATURE REVIEW .....	4
III METHODOLOGY .....	29
IV FINDINGS .....	36
V DISCUSSION.....	78
REFERENCES .....	86
APPENDICES	
Appendix A: HSR Approval Letter.. .....	88
Appendix B: Informed Consent Form .....	89
Appendix C: Interview Guide.....	91
Appendix D: Demographic Information .....	94
Appendix E: Recruitment Email.....	95

## LIST OF TABLES

Table .....	Page
1. Demographic Data .....	38

## **CHAPTER I**

### **Introduction**

In 1990, Congress passed the Americans with Disabilities Act, a sweeping civil rights law which made discrimination illegal across several areas of daily life including: housing, employment and consumerism (Zames, Fleischer & Zames, 2001, p. 94). This legislation was the culmination of advocacy from an organized disability rights community, written from a theoretical perspective called the social model of disability which locates disability within the environment—and not within the individual (Olkin, 1999, p. 26). Despite increased legal protections, people with disabilities continue to be subject to heavy stigma and negative attitudes which are ingrained in society (Olkin, 1999, p. ix). Given the high rate of contact between people with disabilities and social workers, it is important to increase our understanding of social workers' perceptions of disability. Additionally, very little is known about the approaches and theories clinicians use while working with this diverse population in private practice psychotherapy.

My research explores the changing perceptions (attitudes and language use) of clinical social workers toward clients with disabilities through a qualitative exploration of clinicians' experiences working with this population over time. For the purpose of my study, 'person with disability' will be defined broadly using the ADA's three prong definition: Under ADA, an individual with a disability is a person who: (1) has a physical or mental impairment that



substantially limits one or more major life activities; OR (2) has a record of such an impairment; OR (3) is regarded as having such an impairment.

For this project, I conducted nine interviews with experienced clinical social workers who have experience working with clients with disabilities. Participants were asked to present a case study of a client with a disability whom they had worked with for at least one year in their private practice. Interview questions were developed in order to answer the question, *how do experiences working with clients with disabilities shape clinical social workers' perceptions of disability?* The interview schedule was divided into the following four categories: the clinician's understanding of their work with the client; what guides the clinician's approach to the work; the clinician's transactional language and attitudes with the client; and the clinician's recommendations and observations about working with clients with disabilities.

A plethora of literature in the area of disability studies exists. One of the fundamental theories promoted by this discipline is the social model of disability. In contrast to the traditional medical model which pathologizes disability within the body, the social model of disability locates disability within the social and physical environment. “[The social model] posits that disability is a social construction, that the problem lies not within the person with disabilities but in the environment that fails to accommodate persons with disabilities and in the negative attitudes of people without disabilities” (Olkin, 1999, p. 26). However, a number of studies have concluded that disability theory is not being taught in social work programs (Leslie, 2008; Gourdine and Sanders, 2002; Gilson and Depoy, 2002).

Not surprisingly, a review of existing studies shows that social work students and social workers continue to hold similar attitudes as the general public toward individuals with disabilities (Smith & McCulloch, 1978; Olkin, 1999; Miller, 2002). Haller, Dorries and Rahn

(2006) found that outdated terminology such as “wheelchair bound” are still commonplace in popular media which reflect society’s norms. However, Arokiasamy and Strohmer (1994) offered compelling evidence that language use in therapy sessions is not as important as the use of good therapy skills in assessing therapist credibility (as assessed by both disabled and nondisabled individuals). A review of narrative and relational theories revealed that widely practiced social work models are situated to align with the social model of disability. However, these models do not explicitly discuss practice with clients with disabilities; nor are they empirically studied with this population.

Given the clear disconnect between disability theory and social work theory and practice, I felt there was a need for an exploratory study which probed into clinical social workers’ experience working with clients with disabilities. Several themes developed out of the interviews which are presented and explored in the findings chapter and discussion chapter, respectively. The findings of this study have a number of important implications in the area of social work education and clinical practice, which are also laid out in the final chapter.

## **CHAPTER II**

### **Literature Review**

This chapter provides a review of the literature that is relevant to my study of clinicians' work with clients with disabilities. My literature will cover the history of disability movements and pertinent legislation, multiple disability theories, empirical research related to language use and attitudes of social workers, and clinical social work theories that are relevant to clinical practice with clients with disabilities. I will also highlight case examples in the literature while reviewing theory. This chapter will conclude with a short summary and I will identify a gap in the literature which my study will attempt to fill.

#### *Disability Rights Movement and the Americans with Disabilities Act*

The foundation of a unified disability rights movement was shaped by grassroots organizations working toward securing rights for individuals with particular impairments, including the Independent Living Movement (ILM), Disabled In Action, Disability Rights Education and Defense Fund, Justice For All, and American Disabled for Accessible Public Transit (ADAPT) (Zames Fleischer & Zames, 2001, p. 71). Each of these movements advocated for civil rights and policy changes for equal rights and services for their groups. The ILM worked to deinstitutionalize services for individuals with major disabilities, and set up community based, client centered centers (Mackelprang & Salsgiver, 1996, p. 9). A case

example of a modern ILM will be explored later in this chapter under the heading the social model.

In 1973, Congress passed the Rehabilitation Act of 1973 which included Section 504 which made discrimination against people with disabilities in publically funded institutions illegal. The passing of Section 504 spurred further political and legal action within the growing disability rights movement (Zames, Fleischer & Zames, 2001, p. 51). Olkin (1999) calls Section 504 “Our ‘Stonewall,’ the turning point in the collective history of persons with disabilities” (p. 138). However, Section 504 of the Rehabilitation Act was limited to prohibiting discrimination in federally funded institutions, and did not address private discrimination (Colker, 2005, p. 12). While the law was not sweeping, it fueled the movement to continue its fight for civil rights legislation, which was finally realized in the Americans with Disabilities Act (ADA) of 1990. The ADA is a sweeping civil rights law which protects Americans with disabilities from discrimination across several areas of daily life such as housing, employment and consumerism.

During the 1980s, President Reagan formed the National Council on the Handicapped, a fifteen member committee which issued two reports: *Toward Independence* (1986) and *On the Threshold of Independence* (1988). These documents advocated for legislation which emphasized equal opportunity rather than income support (Colker, 2005, p. 26). During his campaign for the presidency, Vice President George H. Bush promised support to the ADA (Colker, 2005, p. 5). Once elected, President Bush appointed Richard Thornburgh as Attorney General, and asked him to work with Congress on the ADA. Thornburgh’s son had a serious brain injury, and he and his wife were strong advocates for disability rights (Colker, 2005, p. 5). Within Congress, the ADA found proponents in Senators and Congressmen with disability connections, such as Representative Tony Coelho, who had epilepsy, and Senator Lowell

Weicker, who had a son with Down's syndrome (Colker, 2005, p. 16 & 27). Colker (2005) contends that without the dedication of members of Congress with disability connections, the ADA would have been much weaker (p. 27). The ADA borrowed language from the Civil Rights Act of 1964 and the Rehabilitation Act of 1973 (Colker, 2005, p. 17). The ADA was written by disability rights activists from the perspective of the social model of disability, which views disability as shaped by disabling environments (Olkin, 1999, Gilson & DePoy, 2002). According to the social model of disability, the solution to disability is to remove disabling environments by providing accessibility and accommodations (two terms which are found throughout the ADA). The ADA borrowed language from the Civil Rights Act of 1964 because it viewed disability as a distinct minority group. In the next sections, I will examine two major models of disability, the social model and the medical model.

### *The Medical Model of Disability*

Disability has traditionally been conceptualized in terms of individual deviance from the norm; this understanding is called the medical model. "The [medical] approach to disability is based on medical explanations of individual human conditions" (Gilson & Depoy, 2002, p. 154). This model is occasionally referred to in the literature as the diagnostic model, though I will exclusively use the more common term 'medical model' to be consistent. Olkin (1999) defines the medical model as individual deviance. "Disability is seen as a medical problem that resides in the individual. It is a defect in or failure of a bodily system and as such is inherently abnormal and pathological" (p. 26). The medical model approach is taught to medical students and other allied health professionals including social work students (Gilson and Depoy, 2002).

The medical model is useful in treating patients with acute illness which can be clearly diagnosed and treated (Brashler, 2006, p. 541). When a patient presents in a medical setting with acute symptoms, the medical team completes an assessment (physical and history) on the patient, and determines a diagnosis and course of treatment (Brashler, 2006, p. 451). The acute patient must cede autonomy and control to the health-care professionals (Brashler, 2006, p. 451). “This is easily seen in the patient hospitalized for an appendectomy, who is instructed on what to eat, what to wear, when to get out of bed, and when to interact with visitors” (Brashler, 2006, p. 451). Brashler (2006) argues that the medical model is less applicable to individuals with chronic illness or disability: “First and foremost the diagnosis of a chronic or permanent condition—one not amenable to cure—seems to trap the individual in the ‘patient’ or ‘sick’ role forever” (p. 451). Disability activists and scholars developed the social model as an alternative way to define disability; this model will be reviewed in the following section.

### *The Social Model of Disability*

Olkin (1999) offers the following definition of the social model (also referred to as the minority model or constructionist model):

The minority model (also called the ‘social model’) is a new paradigm from which to view disability. It posits that disability is a social construction, that the problem lie not within the person with disabilities but in the environment that fails to accommodate persons with disabilities and in the negative attitudes of people without disabilities. Persons with disabilities are seen as a minority group-in the same way that persons of color are a minority group-that has been denied its civil rights, equal access, and protection (p. 26).

Gilson and Depoy (2002) offer a similar definition for the social model: “Individuals are perceived to be disabled by marginalization, oppression, and hostile environments” (p. 160).

The social model offers an alternative definition and way of viewing disability. Instead of being

located inside an individual, disability is now viewed in terms of disabling environments. The environment not only represents physical barriers, but may include psychologically disempowering environments such as discrimination and exclusion (Olkin, 1999, p. 36).

The Independent Living Movement is a service delivery model which exemplifies the social model paradigm. French and Swain (2001) studied the Derbyshire Centre for Integrated Living (DCIL), a Community Integrated Living Center in the UK which arose from the independent living model. The center, which opened in 1985, aims to “secure full economic public and social life for disabled people in accordance with their own wishes and desired lifestyles” (French and Swain, 2001, p. 747). The DCIL operates through a social construction of disability (p. 747). Through this model, environmental barriers are considered and adjusted, service deliverers and decision makers are also mainly individuals with disabilities, and empowerment and self determination are more than mere rhetoric (p. 748). French and Swain (1996) argue that “many of the barriers disabled people routinely face have been removed within the organization” as a result of this model (p. 748). This case study represents a British organization which has access to different government resources than American organizations; however, I believe there are elements of the DCIL that can be applied to American organizations. I will examine a critique of the social model later in this literature review.

### *Disability as a Minority Status*

The argument against the medical model (and in favor of the social model of disability and civil rights legislation for people with disabilities) is contingent on the assumption that people with disabilities constitute a minority group. Using representational theory, Mporfu and Conyers (2004) make a compelling argument that disability status is a distinct minority group in

the United States. According to representational theory, a group is defined as a minority if it is restricted by the dominant group in one or more of the following areas: (a) economic opportunity, (b) communicative self-representation, and (c) preferred lifestyle” (Mpofu & Conyers, 2004, p. 143). Mpofu and Conyers (2004) argue that people with disabilities are restricted by the dominant-non disabled group in all three categories.

According to Mpofu and Conyers (2004), people with disabilities are limited in economic opportunities whether they work or not (p. 143). Conyers, Kosh and Szymanski (1998) conducted a qualitative study of employed college graduates with disabilities. The authors found that their respondents faced challenges that their non-disabled peers did not face in finding and maintaining competitive employment (p. 10). Respondents noted that there were disincentives to work, including loss of medical insurance and home attendant services (Conyers, Kosh & Szymanski, 1998, p. 10). One participant noted that the same organization that helped her go to school was threatening to withhold services based on the participant’s earnings:

What drives me nuts about it is here I am someone who they’ve helped pay for my schooling to get a degree, be able to go out to the work force, to get a job, be able to support myself in every way I possibly can. I don’t ask for any extra assistance whatsoever, and I’m somewhat penalized in that I can’t make too much money, otherwise I’ll lose the program. There is no incentive for people to work. And I don’t blame anyone who doesn’t work, but on welfare-there’s no incentive (Conyers, Kosh & Szymanski, 1998, p. 10).

According to Mpofu and Conyers (2004), those individuals who do not work and rely on Social Security and Disability insurance are subject to a heavy stigma; additionally, the current monthly benefit is inadequate in covering living expenses (p. 146).

People with disabilities have also been historically denied from self-defining and labeling their disabilities (Mpofu & Conyers, 2004, p. 146). Although a push to use ‘people first’ language occurred in conjunction with the disability rights movement and the passage of the



Americans with Disabilities Act, non-disabled individuals such as journalists and social workers continue to use disrespectful language (Mpofu & Conyers, 2004, p. 146; Olkin, 1999; Haller, Dorries and Rahn, 2006). Language use around disabilities will be explored later in this chapter.

Mpofu and Conyers (2004) argue that people with disabilities have also been denied the right to live their preferred lifestyle for three significant reasons: (1) cosmetic reasons, (2) political reasons, and (3) cultural reasons (p. 147). People with disabilities were historically considered ugly and removed from society to hide their existence. As a result, people with disabilities were denied citizenship (political rights). Finally, people with disabilities' "life experiences and needs have been regarded as so different from those of ordinary persons as to cause social concern" (Mpofu & Conyers, 2004, p. 147). Although a group must only meet one area of disadvantage to constitute a minority group according to representational theory, people with disabilities have been discriminated against in all three categories. This paper will take the position that people with disabilities are a unique minority group in the United States. However, this view is not universally accepted.

### *Social Work Education and the Social Model*

Gilson and Depoy (2002) assert that social work schools currently teach the medical model approach to working with clients with disabilities. In the authors' opinion, social work schools should teach the social model of disability as an alternative. "While an individual's anomalous physical, behavioral, psychological, cognitive, or sensory conditions may be acknowledged, they are not necessarily perceived as undesirable, in need of remediation, or even relevant to disability" (p. 160). Mackelprang and Salsgiver (1996) argue, "Social work philosophy shares many similarities with the minority model of viewing people and their

environments” (p. 10). Gilson and DePoy (2002) believe that the inclusion of the social model approach in social work education “would reflect social work’s professional commitment to social justice and locate discussions of disability within the larger discourse of diversity” (p. 163).

Several studies have examined existing social work curriculums and have concluded that the social model is all but excluded from social work course work (Leslie, 2008; Gourdine and Sanders, 2002; Gilson and DePoy, 2002). Gourdine and Sanders (2002) researched and analyzed the curricula of 83 social work schools in the United States, scrutinizing course catalogues on the schools’ websites for courses related to disability studies. Of the 83 schools studied, only 12 (16%) offered at least one course with disability content (p. 215). The authors conclude that social work institutions (with the exception of a few programs) are not meeting their obligation to include disability content in their curriculums (Gourdine & Sanders, p. 218-219). Gourdine and Sanders used empirical evidence to demonstrate that social work schools are not preparing students to work with clients with disabilities from a social model perspective.

One critique of Gourdine and Sanders (2002) is the study’s exclusive use of internet sources. It is possible for schools to cancel courses that are under-enrolled and/or offer new courses last-minute. Additionally, schools may fail to upload current course information on their public websites. It would be useful to continue this research by surveying schools through phone and email contact to confirm and gather more accurate information about specific curriculums. Nonetheless, Gourdine and Sanders (2002) findings expose a troubling trend of exclusion of the disability studies in social work curriculums. In the absence of these courses, the medical model stands alone as the only model for working with clients with disabilities.

*The Relationship between Social Workers and Clients with Disabilities*

Mackelprang and Salsgiver (1996) argue that the medical model continues to dominate medical and mental health practices in the United States (Mackelprang & Salsgiver, 1996, p. 9). This is consistent with the literature that highlights the use of medical model curriculums in social work programs (Gilson & Depoy, 2002; Gourdine & Sanders, 2002). Using a case study, Mackelprang and Salsgiver (1996) demonstrate the difference between a social work intervention and a social model intervention for the same client. The client is a 32 year old female who acquired a spinal cord injury in an automobile accident. The client received case management services through a social worker at the hospital, which continued six months after she was discharged. The social worker applied for Medicaid and secured assistive technology and rehabilitation services for the client. After six months, the client became involved in a local independent living center for peer counseling and independent living training. When she had trouble with her Medicaid and needed a commode chair, the client asked her peer counselor for help with these services. Unlike the social worker, the peer counselor taught the client how to obtain these services herself (Mackelprang & Salsgiver, 1996, p. 12). The authors assert that teaching a client how to advocate and obtain services is empowering and fosters independence.

This brief but powerful case example demonstrates the artificial divide between social workers and clients; social workers are professionals, while clients are viewed as passive consumers (French & Swain, 2001, p. 735). French and Swain (2001) argue that there are three elements that dictate the power relationship between professionals and clients: (1) control over the allocation of resources; (2) the legitimization of knowledge, expertise, and skills; and (3) statutory powers. In the first element, the social worker would cease to be needed if she shared all of her resources and knowledge with the client. In the second element, the social worker

believes she holds legitimate power based on her professional degree. The preservation of the medical model constitutes the third element. “Of particular importance to professional-disabled people relations is the maintenance of the status quo by pathologizing and individualizing problems that have been socially and economically created” (French & Swain, 2001, p. 736). Swain, Griffiths and Heyman (2003) conducted a qualitative study which demonstrates French and Swain’s (2001) professional-client power relationship theory in practice.

In their study, Swain, Griffiths and Heyman (2003) investigated counselor’s definitions and understandings of disability, and then explored the implications of disability in terms of the provision of counseling (p. 141). An additional aspect of the research investigated the experience of clients with disabilities in therapy (referred to as counseling within the article) (Swain, Griffiths & Heyman, p. 141). The researchers used grounded theory to guide their qualitative research. After conducting initial interviews with counselors, the researchers met to discuss findings and collaborate in the design of the next stage, interviews with clients with disabilities (p. 141). The researchers asked the therapists to recruit twelve clients with disabilities for the study; they were then interviewed by a different therapist than the one with whom they normally worked. Six of the clients participated in a second interview with one of the researchers (Swain, Griffiths & Heyman, p. 141).

Swain, Griffiths and Heyman (2003) found that the counselors generally helped clients accept and control emotions and constraints caused by their disability (Swain, Griffiths & Heyman, 2004, p. 145-146). For example, one client in the study felt shame every month when a delivery man brought her a large box of incontinence underwear with its contents clearly labeled. When the client brought this up to her therapist, the therapist encouraged her to explore her shame. “Embarrassment is reinforced as the problem, rather than the treatment to which this

client has been subjected” (Swain, Griffiths & Heyman, 2003, p. 146). The interviews with both counselors and clients demonstrate the unequal power relationships described by French and Swain (2001) and Mackelprang and Salsgiver (1996). Had the therapist worked from a social model perspective, she could have empowered the client to call the shipping company and ask for the box to be covered with brown paper to protect the client’s privacy.

### *Critiques of the Social Model*

Daniels, Rose and Daniels Zide (2008) offer an interesting critique of the social model of disability. Daniels, Rose and Daniels Zide (2008) argue that disability “is the result of both significant impairment and social exclusion, not just one of them” (p. 76). In other words, the authors argue that disability must be examined from both medical and social perspectives. The authors state that motor and sensory impairments lend themselves to the social model.

“Arguably, much of the disadvantage suffered by people with motor or sensory disabilities results from social exclusion, since so many of their other capabilities remain intact and allow them to perform the full array of complex cognitive and social tasks involved in work and other parts of life” (Daniels, Rose & Daniels Zide, 2008, p. 76). Conversely, people with brain injuries and/or mental illness “may be disadvantaged not only by social exclusion but also by their cognitive and emotional impairments” (Daniels, Rose & Daniels Zide, 2008, p. 78-79).

Daniels, Rose and Daniels Zide (2008) use two case studies of individuals with traumatic brain injuries (TBIs) to illustrate their argument. The clients N.E. and G.Z. acquired brain injuries following a motor vehicle and motorcycle accident, respectively. Both clients went through a rehabilitation program where they learned compensation skills for their permanent deficits. N.E. was a young woman who was enrolled in graduate school at the time of her

accident; her goal in rehabilitation was to continue her studies. After completing rehabilitation, N.E. enrolled in another graduate program with several accommodations in place. N.E. was unable to keep up with the pace of the work and dropped out, resulting in a great depression (Daniels, Rose & Daniels Zide, 2008, p. 59).

G.Z. is a 27-year-old man who owned a successful business before acquiring his TBI. G.Z. “had to adjust to the tedious slow pace of rehabilitation” (Daniels, Rose & Daniels Zide, 2008, p. 59). G.Z. was unable to keep his business, but eventually succeeded as a peer specialist working with other brain injury patients (Daniels, Rose & Daniels Zide, 2008, p. 60). The authors argue that G.Z. adjusted to his impairment better than N.E. because he was able to lower his expectations for success. “G.Z. is an example of a survivor of brain-injury who was able to transform his attitude about himself and achieve a new ego-identity” (Daniels, Rose & Daniels Zide, 2008, p. 60).

Daniels, Rose and Daniels Zide (2008) attempt to argue through their case examples that no matter how many accommodations are given, some impairments will truly prohibit individuals from fully participating in society, and therefore disability cannot solely be located within the environment. My concern with Daniels, Rose and Daniels Zide’s argument is that the authors are taking the liberty to assess N.E. and G.Z.’s level of adjustment to their respective disabilities based on the authors’ subjective interpretation of what they believe constitutes successful adaptation following a TBI. The authors do not interview N.E. or G.Z., nor do they follow N.E. or G.Z.’s longitudinal progress. Rather than normalizing N.E.’s depression response, they pathologize it by attributing it to N.E.’s inability to adjust to her new limitations. Daniels, Rose and Daniels Zide (2008) do not suggest that N.E. seek psychotherapy or anti-depression medication to treat her depression; instead, they imply that she must lower her

expectations and let go of her graduate school dreams in order to beat her depression. While Daniels, Rose and Daniels Zide (2008) make a valid point that both N.E. and G.Z. will face real limitations for the rest of their lives, they may not have considered how negative environmental responses could affect each individual's dreams as much as their impairments.

### *The Language of Disability*

An increased focus on the importance of language around disabilities developed out of the disability movement. Olkin (1999) argues “any group—whether based on gender, race, ethnicity, sexual orientation, religion, and so on—should be allowed to name itself (p. 37). “The current and preferred term [of disability advocates is] “person with a disability.” This phrasing places the person first (i.e., the personhood is unaffected by the condition) and relegates disability to a secondary position” (Olkin, 1999, p. 39). This terminology, as previously mentioned, will be used throughout this paper in order to respect the autonomy of the disability community. The term ‘disabled’ is preferred in British literature; I will use this wording only in direct quotes from relevant literature.

Olkin (1999) cites some common terms which oppress people with disabilities: “polio victim,” “the cerebral palsied” or “the retarded,” “deaf and dumb,” and “wheelchair bound” (p. 42). Olkin (1999) offers an alternative perspective on the term ‘wheelchair bound’: “the wheelchair represents not loss of function but restoration of mobility; the wheelchair represents wings” (p. 42). Using the social model framework, one can see how bizarre it is to assert that a wheelchair-user is bound to his wheelchair. Olkin argues the opposite; he is made more independent by it! However, this language is deeply ingrained in our socialization and is used in everyday conversations without a second thought. Studying newspaper articles over a ten year

period, Haller, Dorries and Rahn (2006) demonstrated that journalists continue to use the term “wheelchair bound” in addition to other non-preferred disability language in mainstream news articles.

Haller, Dorries and Rahn (2006) conducted a study of the use of disability terminology by journalists in two major newspapers, The New York Times and the Washington Post, during November and December of 1990, 1995 and 2000. By searching for the keywords “disabled,” “disability,” “disabilities,” “handicapped,” “crippled,” “cripple” and “crippled,” the authors were able to isolate articles that discussed individuals with disabilities and determine whether there were any changes in the use of such terms over the period studied (Haller, Dorries & Rahn, 2006, p. 68). Haller, Dorries and Rahn (2006) also conducted a similar analysis of wheelchair language; they searched for articles containing “confined to a wheelchair,” “wheelchair-bound,” and “wheelchair user.” This search included all articles from the years 1990, 1995, and 2000 (p. 68). The authors hypothesized that the passage of the ADA in 1990 had brought new awareness of disability issues and person first language to the American public and media (Haller, Dorries & Rahn, 2006, p. 66-67).

The authors found that there were some modest increases in the use of people first language in the articles, including the use of the term “person with disability/persons with disabilities” in both newspapers (Haller, Dorries & Rahn, 2006, p. 69). Additionally, there were decreases in the use of the term “crippled” (as a verb or adverb) in the New York Times (ten articles in 1990, six articles in 1995, and zero articles in 2000) (p. 69). The Washington Post mentioned “crippled” (as a verb or adverb) ten times in 1990, five times in 1995, and seven times in 2000. The authors noted modest improvements in positive (people first) language use,



and decreases in stigmatizing language use across both papers (Haller, Dorries & Rahn, 2006, p. 69 and 72).

By using unbiased key word searches of publically available print material, the authors' findings were fairly objective and painted a picture of language use in popular media. One critique I would offer is the small sample of articles used in the disability terminology research (two months out of every five years). A wider sampling would yield more accurate trends. Additionally, I would be very interested in seeing the results of the same study in 2005 and 2010, had the study continued. A similar study could be conducted by searching social work journals for key disability terminology, which may reveal unbiased language use by social worker researchers. However, it could be argued that such a study would be less relevant as more people are exposed to mainstream newsprint than social work research. Nonetheless, many social workers read peer reviewed articles and their language use with clients may be influenced by such articles.

Arokiasamy and Strohmer (1994) conducted a quantitative study of the effects of politically correct language and counselor skill level on counselor (therapist) credibility. The study consisted of 110 individuals (61 non-disabled and 49 individuals with disabilities) (p. 307). Participants listened to two of six excerpts of a fictitious counseling session (p. 308). The excerpts all comprised of the same clinical situation, but varied in counselor response. A client (who uses a wheelchair) tells her therapist that she is concerned with how a teacher is treating her. The counselor responds in three different ways, either using "politically correct," "politically incorrect," or "ultra correct" language. Different versions of the tape also varied in quality of response (either good attending skills or poor attending skills) (p. 308). Politically correct language included person first language; politically incorrect language included terms

such as “your being impaired,” “suffering a handicap,” and “because of your unfortunate condition” (Arokiasamy & Strohmer , 1994, p. 309). The researchers defined “ultra correct” language as phrases such as “you are handi-capable,” “your being an inconvenienced person,” and “differing abilities” (p. 309). Before developing the audiotapes, the researchers consulted disability advocates in order to validate phrases in the three categories (p. 309). After listening to the tapes, participants were asked to rate the counselor on the tapes using the Counselor Rating Form-Short version (CRF-S) (p. 307). The CRF-S tests counselors on three scales, expertness, attractiveness, and trustworthiness (Arokiasamy & Strohmer, 1994, p. 309).

Arokiasamy and Strohmer (1994) hypothesized that participants with disabilities would rate counselors who used politically incorrect and “ultra correct” language more negatively than counselors who used politically correct language (p. 307). This hypothesis turned out to be unsupported. “There was no significant effects for politically correct language on any of the variables” (p. 310). The only statistically significantly findings in the study were between participants’ perceptions and counselor skill level. “The more skilled counselor was rated significantly higher on all of the dependent variable, and the less skilled counselor was rated significantly lower on all of the dependent variables by both the disabled and nondisabled groups” (Arokiasamy & Strohmer, 1994, p. 310).

In discussing their findings, Arokiasamy and Strohmer (1994) suggest that people with disabilities have “adjusted to some level of insensitivity and can succeed despite a general lack of sensitivity” (p. 311). The authors offer no empirical or anecdotal evidence of this hypothesis. However, Conyers, Kosh and Szymanski (1998) found anecdotal evidence that individuals with disabilities developed coping skills to overcome negative expectations, discrimination and other barriers to career success. “Many participants used the negative expectations of others as a

challenge to motivate themselves” (p. 7). Arokiasamy and Strohmer (1994) suggest that the focus on politically correct language is over inflated; they state, “Preoccupation with terminology can sometimes be distracting” (p. 311). While I agree with the researchers’ assertion that counseling programs should focus on skills-building, I disagree that language use by counselors is unimportant in the therapy relationship. These findings suggest the importance of therapist skill and the content of speech over the specific words that are being used.

### *Social Workers’ Attitudes Toward Disability*

Existing studies have demonstrated that social workers’ attitudes towards individuals with disabilities are only slightly more favorable than the attitudes of other professionals or the general public (Smith & McCulloch, 1978; Olkin, 1999; Miller, 2002). Smith and McCulloch (1978) sought to answer the question: do social work students hold differing attitudes toward people with disabilities when compared with other students? The authors surveyed 400 non-disabled social work students and non-social work students in the UK (Smith & McCulloch, 1978, p. 190). Student participants represented both undergraduates and graduate students. Factors that were examined in the study included gender, area of study (social work or non social work study), and close contact to person(s) with physical disability. The authors defined close contact as having a close friend or relative with a physical disability (Smith and McCulloch, 1978, p. 187). The authors categorized their findings by attitudes toward disability for each group in order of least favorable to most favorable in the following order: *Non-social work males with no contact; non-social work males with contact; social work males with no contact; non-social work females with non contact; non-social work females with contact; social work males with contact; social work females with no contact; and social work females with contact* (Smith

and McCulloch, 1978, p. 193). This research, though relevant to my question, precedes the Americans with Disabilities Act and focuses exclusively on British students. However, the authors uncover several factors which should be considered in any study that assesses attitudes of social workers, including the relevance of proximity to individuals with disabilities in shaping attitudes toward this same group.

Olkin (1999) draws on several studies to develop a picture of various groups' attitudes towards people with disabilities. According to Olkin, (1999) increased levels of education are associated with positive attitudes toward individuals with disabilities (p. 65). Licensed social workers must hold a Masters Degree or higher to practice social work, suggesting that they are included in this category. However, Olkin (1999) cites a study by Chan et al. (1988) which finds that therapists' attitudes toward individuals with disabilities are no different from attitudes held by the general public (p. 65). Culture, gender, age, and proximity to individuals with disabilities are also factors which influence attitudes toward disability (Olkin, 1999, p. 65). Olkin (1999) also notes that there is a hierarchy of more and less stigmatized disabilities (p. 70-71). Miller (2002) conducted a study to determine the attitudes of allied health students, including social work students toward individuals with disabilities. Miller (2002) believed that this student population was important to study: "As future allied health practitioners, these students are likely to provide services to persons with disabilities and thus have the potential to contribute to or hinder the independence of persons with disabilities" (p. 13). The study included social work, nursing, occupational therapy, physical therapy, and speech communication students in a rural state (p. 13). The study utilized a quantitative survey which assessed attitude and knowledge of people with disabilities. Miller (2002) argues that previous attitude studies have been susceptible to "socially desirable responses (p. 15). Therefore, some of the attitude

questions in his study were disguised as knowledge questions to prevent students from answering questions about attitudes with responses that they feel are most acceptable (Miller, 2002, p. 13). In addition to questions about knowledge and attitudes, students were asked about the following: discipline, frequency of contact with persons with mental retardation, and intensity of contact with persons with mental retardation (Miller, 2002, p. 18). Miller (2002) found that social work students had the most positive attitudes of all allied students, despite having the same self-reported amount of contact with individuals with mental retardation (p. 18). The researcher also noted a correlation between older students and students in a higher year of schooling and positive attitudes (p. 19). Women also held slightly better attitudes than men (p. 18).

One limitation of Miller's research is the exclusive study of attitudes toward mental retardation, and exclusion of other types of disabilities. However, Miller's study demonstrates that social workers do hold more positive attitudes than other allied health professionals. Interestingly, occupational therapy students held the lowest attitudes toward individuals with mental retardation. However, Miller (2002) also notes that the social work students were older and had significantly more years of education, suggesting that no conclusions can be drawn about the difference in attitudes between these two groups due to various correlating factors (p. 22). Miller would need to interview participants to clarify how their education, age, gender, frequency of contact with individuals with mental retardation, etc. affected their attitudes and knowledge.

Olkin (1999), Smith and McCulloh (1978), and Miller (2002) all identify factors which are relevant to shaping attitudes toward people with disabilities, including having friends or family members with disabilities, an individual's education level and area of study. However,

none of the aforementioned authors is able to offer an explanation for why these factors affect attitudes.

### *Relevant clinical theories / approaches*

According to the literature reviewed in this chapter, the social model of disability developed out of the disability movement and has not been integrated into clinical education and practice. However, there are several clinical social work approaches which I believe are congruent with this model. This section of the literature will summarize those clinical theories that relate to the social model of disability. I will review postmodern approaches including collaborative language systems and narrative therapy. In these related theories, client problems are viewed as the result of dominant cultural narratives. I will also review relational and intersubjectivity theories which emphasize the dynamics of the therapist and client in creating meaning in the therapeutic relationship. Although these theories are not supported by empirical data in the area of working with individuals with disabilities, I will use these theories as a lens to frame and analyze my study.

Narrative therapy ascribes meaning to words and stories to make sense of one's life. "Since the stories that persons have about their lives determine both the ascription of meaning to experience and the selection of those aspects of experience that are to be given expression, these stories are constitutive of shaping of persons' lives (White, 1990, p. 40). According to Goldenberg and Goldenberg (2000), the therapeutic goal of narrative therapy is to "collaborate or consult with people and help them construct and realize their true dreams, visions, values, beliefs, spirituality, and commitments" through re-shaping their story (p. 315).

Two important features of narrative therapy are that the therapist is not an objective truth knower (Goldenberg & Goldenberg, 2000, p. 315) and personal narratives are influenced by the dominant culture's narrative (Goldenberg & Goldenberg, 2000, p. 314-315; White, 1990, p. 18-19). White (1990) drew heavily on Foucault's theory of power in his writing (p. 19). For the purpose of this study, I will draw only on those aspects of Foucault's theories which are most relevant to language use and the social model of disability. According to Goldenberg and Goldenberg (2000):

Foucault saw language as an instrument of power; he insisted that certain "stories" about life, perpetuated as objective "truths" by the dominant culture; [these stories] help maintain a society's power structure and eliminate alternate accounts of the same events (for example, regarding what constitutes normal sexuality, or what behavior should be classified as pathological, or how to react to members of a minority community, or what it takes to be a "real" man" (p. 314-314).

Although neither Foucault nor White explicitly discussed people with disabilities in their writings, Mporu and Conyers (2004) argue that people with disabilities qualify as a minority group whose narrative is silenced by the dominant group. Applying Foucault's theory, the medical model can be seen as "truth" as held by the dominant culture (certainly led by physicians and other "experts"). In his writing, Foucault "advocated helping people to get out from under the yoke of the culture's dominant discourses. He urged that certain dominant culture narratives be challenged" (Goldenberg and Goldenberg, 2000, p. 315). White (1990) also argued that narratives must be challenged and changed in the therapeutic setting (p. 28-29). Therefore, I believe that narrative therapy can be incorporated into clinical work with individuals with disabilities as a way to reframe the meaning of disability.

Like Michael White's narrative therapy, Gollishian and Anderson's collaborative language systems approach emphasizes the importance of language. Goldenberg and Goldenberg (2000) offer a concise summary this theory: "To advocates of this view, human

systems are essentially language and meaning-generating systems. Therapy systems are no exception; therapist and client together create meaning with one another as they discuss a “problem” (p. 312). In this approach, the therapist takes a stance of “not-knowing” and assumes that the client is the expert in his/her own life (Anderson, 2005, p. 502). Anderson (2005) explains,

In therapy, the client’s language—the customary and the familiar—and the meanings it embodies take precedence over the language and meanings of the therapist, just as the client’s language and meanings, not the therapist’s, are the starting point for the client’s and the therapist’s creation of new meaning. That is, the therapist enters the relationship and conversation as a learner (p. 500).

Narrative therapy emphasizes language use, subjective truths and power/knowledge.

Collaborative language systems approach emphasizes meaning-making, client as the expert, and taking a stance of not-knowing. These concepts are congruent with the social model of disability in that the social model seeks to alter dominant truths and externalize a problem (disability) away from the individual and into the environment. However, neither of these approaches emphasizes the treatment relationship or the role of empathy or the use of transference/countertransference in therapy. For this, I turn to a summary and discussion of relational theory and inter-subjectivity.

Relational theory recognizes the importance of the therapist and client exerting mutual influence on one another; this theory is known as a “two person model” (Hadley, 2008, p. 210-211). In relational theory, the relationship itself is a means to client change. “The relationship, the growth of mutual recognition, reflection, renegotiation, and regulation within the clinical dyad is understood as the primary means to change by those working from a relational perspective” (Hadley, 2008, p. 224). Relational theory charges that each individual in the dyad has his/her own subjectivity; “neither is privileged as “the knower.” (p. 212).



The exploration of countertransference is extremely important in relational theory. In referring to countertransference here and throughout this study, I will be using Kernberg's (1965) definition of it as "The total emotional reaction of the psychoanalyst to the patient in the treatment situation." Hadley (2008) emphasizes the importance of the clinician identifying and naming countertransference as it arises (p. 212-213). By noticing reactions to clients, clinicians use countertransference to gain insight on the dynamics and client's experience. Inter-subjectivity is often used synonymously with relational theory. Inter-subjectivity is a developmental achievement which "enables us to consider the experience of each person (or subject) as he influences the experience of the other in ways that are reflexive, not unidirectional" (Hadley, 2008, p. 219). In other words, inter-subjectivity is a person's ability to have empathy for others.

Dominant culture influences both the way we think about our identity and place in the world, and what we bring to our relationships. Dominant culture tends to emphasize our weaknesses and impairments. Narrative theory gives clinicians a way to adjust a dominant culture, while relational theory gives room for outside experiences to enter the therapeutic space. Practicing from a strengths-based perspective allows clinicians to partner with clients to discover client strengths, which can also create a shift in the client's life story. These three theories are all congruent with the social model. In designing the interview guide for this research study, I have used these theories to help guide me in crafting questions since they contain material useful for understanding the processes that may occur in any therapeutic alliance—and are particularly useful for the focus of this study.

## *Summary*

The disability rights movement created a new paradigm for thinking about disability as an environmental disadvantage, rather than an internal abnormality (Olkin, 1999). One's orientation toward the medical or social model is largely dependent on whether you view disability as a distinct minority status or whether you view disability as a medical concern. My review of the literature revealed that social work students and social workers continue to be taught medical model practices (Gilson & Depoy, 2002) and hold similar attitudes to the general public about individuals with disabilities (Smith & McCulloch, 1978; Olkin, 1999; Miller, 2002). Haller, Dorries and Rahn (2006) demonstrate that outdated medical model terminology such as "wheelchair bound" are still commonplace in popular media which reflect society's norms. However, Arokiasamy and Strohmer (1994) offered compelling evidence that language use in therapy sessions is not as important as the use of good therapy skills in assessing therapist credibility (as assessed by both individuals with disabilities and nondisabled individuals). A review of narrative and relational theories revealed that widely practiced social work models are situated to align with the social model of disability. However, these models do not explicitly discuss practice with clients with disabilities; nor are they empirically studied with this population.

The literature revealed a gap in social work education in teaching the social model of disability. As a result, several authors found that social workers' attitudes are either no better, or only marginally better than the attitudes of other groups of professionals (Smith and McCulloch, 1978; Olkin, 1999; Miller, 2002). These researchers identified variables which may affect attitudes, such as proximity to people with disabilities, gender, education level, and career discipline. The majority of the literature relied on quantitative research methods, leaving a

further gap for descriptive qualitative studies to explore the subjective meaning of these findings. My study will attempt to fill these gaps in the literature by investigating what factors have shaped clinicians' approaches in their work with clients with disabilities. I also hope to understand through my interviews if, and how actual work with clients with disabilities influences clinician's perceptions of disability.

## CHAPTER III

### Methodology

The research question for this study was: *How do experiences working with clients with disabilities shape clinical social workers' perceptions of disability?* A qualitative, semi-structured interview method was chosen for this study in order to explore the subjective experiences of clinicians who work with clients with disabilities. A flexible interview schedule was developed to explore my research question (Appendix C). For the purpose of this study, 'person with disability' will be defined broadly using the ADA's three prong definition: Under ADA, an individual with a disability is a person who (1) has a physical or mental impairment that substantially limits one or more major life activities; OR (2) has a record of such an impairment; OR (3) is regarded as having such an impairment.

After reviewing the literature, I discovered that very little was known about the subjective experiences of clinical social workers who work with clients with disabilities; therefore it was important to ask inductive, exploratory questions rather than develop a survey or based on a deductive method. In contrast to quantitative methods, "qualitative studies seek to convey the complex worlds of respondents in a holistic manner using "thick description" rather than particularistic categories and variables" (Padgett, 1998, p. 2). Themes were only realized after the process of data collection through interviews took place. At this time, I read and coded

transcriptions of each interview, discovering several prominent themes (see Findings and Discussion chapters for elaboration).

### *Sample*

My sample consisted of nine clinical social workers in the New York City metro area. In order to participate in my study, informants had to meet the following criteria: (1) be a licensed social worker with three or more years of postmasters experience in direct practice with clients in either agency or private practice settings; (2) currently be in private practice; and (3) worked with one or more client(s) with disabilities for at least one year.

Due to time and geographical constraints, my sample was not random. Participants were recruited through personal and professional networking and snowball sampling. Informants were asked for the names of other social workers who may be qualified and/or interested in participating in my study. I emailed a recruitment letter to potential informants with information about my study (Appendix E). I also recruited informants by mass emailing the listserv of the New York State Society for Clinical Social Work ([nysscsw.org](http://nysscsw.org)). The New York State Society for Clinical Social Work (NYSSCSW) is an organization that provides educational, professional and legislative services to its members. Additionally, members can advertise their practice on the organization's website. NYSSCSW was chosen as a source of recruitment because it exclusively serves clinical social workers in private practice. Seven informants were recruited through snowball sampling and two informants were recruited through the NYSSCSW list serve email.

### *Data Collection*

Data was collected through eight interviews with social workers who met the selection criteria outlined above. A tenth informant was recruited through the NYSSCS list serve and interviewed; her data was not included in this study because she did not meet the full criteria outlined in my HSR. Procedures to protect the rights and privacy of informants were presented to the Human Subject Review Board at Smith College School for Social Work before data collection began. Approval of the project assured that the study was in accordance with the NASW Code of Ethics and the Federal regulations for the protection of human research subjects. Participants were emailed a letter of informed consent (Appendix B) detailing the nature of the project and the risks and benefits of participation. Each informant signed and received a copy of the consent form prior to the interview. An additional copy was signed and retained for the researcher's records. Participants were given several opportunities to ask questions about the study, data use, and other inquiries during initial email contact and at the beginning and end of the interview.

Interviews lasted between 30 and 60 minutes, and took place between January 27, 2012 and March 23, 2012. Eight interviews were conducted in person with informant, while one interview was conducted over Skype (a free internet phone service) using a webcam. Interviews were recorded on an Android phone using an application called RecForge Lite, version 2.0.5. The application is available for free download on the Android Market. Interviews were then transferred onto my personal computer and immediately deleted from the phone. Files corresponding to transcriptions and audio files were labeled with code names to disguise the identity of participants. At the end of the study, all data was removed from the computer, transferred to disc, and stored in a locked cabinet with other confidential participant data.

An open-ended interview process was chosen to collect data for this study to obtain subjective experiences from participants which was better captured through narrative responses. The semi-structured interview provided flexibility for elaboration to responses. As Padgett (1998) notes, “A successful interview is one in which the interviewer has elicited valuable information by observing, listening, probing, and synthesizing information on the spot when necessary” (p. 62). By obtaining the participant’s point of view, the reader would be able to have a glimpse into the participant’s feelings, motivations, memories, and experiences.

A flexible interview schedule with 18 questions and possible probes was self-developed to explore my research question (See Appendix C for full interview guide). The questions were formulated based on social work and disability theory. Feedback was received from my RA and the Smith College HSR committee. The final draft of the interview schedule incorporates this feedback. As will be discussed in the following chapter, two additional questions were asked after reflecting on early interviews.

At the start of each interview, informant were handed a demographic information questionnaire with five open-ended demographic questions; informants were reminded that answering any/all questions was optional. Each participant elected to fill some or all of the demographic questionnaire; only two questions were left blank (illustrated in Table 1). Informants were then asked to provide a detailed narrative history of one current or previous clinical case with an individual with a disability including a bio/psycho/social and the client’s presenting problem(s). I divided the interview schedule into four major areas of questioning, each containing multiple probes for assisting with the exploration. These areas were: the clinician’s understanding of their work with the client; what guides the clinician’s approach to

the work; the clinician's transactional language and attitudes with the client; and the clinician's recommendations and observations about working with clients with disabilities.

There was minimal risk or discomfort associated with participation in this study. Padgett (1998) argues that the majority of research participants welcome the opportunity to tell their story, reducing the likelihood that "emotions cause more than momentary interruptions" (p. 63). In this study, clinicians were asked to disclose their personal reflections around changes in their work with clients with disabilities. In this exploration, I explicitly asked about their attitudes and language use. While these questions could have caused mild discomfort in participants, participants were free to choose not to answer questions for any reason (including discomfort). Informants were not provided referrals for mental health services due to this minimal risk and participants being licensed clinicians who can seek peer or supervisory support.

Participants may benefit from sharing and gaining new insight in their clinical work, which may positively influence future work with clients with and without disabilities. Participation in this study may also provide invaluable information to the providers who will have the opportunity to learn from the clinicians' perspectives. Participants were not compensated for their participation in this study.

By conducting in-person interviews, I was unable to guarantee anonymity, but I took every step to protect confidentiality of my informants and their clients. Confidentiality was maintained throughout this study in accordance with Federal guidelines. Real names were immediately replaced with numerical codes in order to protect informants' and their clients' privacy. Informants were instructed to give aliases when discussing their clients. Any writings or publications on this topic will be presented in the aggregate. Any quotes used for illustrative purposes did not include identifying information. My research adviser had access to data only



after identifying information was removed. The information gathered (audio recordings, transcriptions, notes, and signed informed consent forms) will be locked for a period of three years. Electronic data will be password protected and kept for the same period of time. After that three-year period, all data will be destroyed when no longer needed, or kept safely stored.

Participation in my research study was voluntary and participants were allowed to refuse to answer any or all questions. Additionally, participants were informed that they could withdraw from my study and have their data destroyed upon request any time before April 15, 2012. Participants were asked to contact this researcher at the number or email stated in the informed consent if they chose to withdraw from the study, or if they had any questions regarding this process.

### *Data Analysis*

Data collected from the demographic information form was analyzed and is presented in Table 1 of the *Findings* chapter. The majority of the data was collected through open-ended interviews with nine informants. Padgett (1998) argues, “One cannot (and should not) collect interview data without also carrying out observation when carrying out a full-scale qualitative study. Observations of the interviewee, the setting, the larger context, and (last but not least) ourselves give much-needed breadth and depth to interview data” (p. 70). Therefore, notable observations were included in raw data as field observations.

After raw data was collected and transcribed, it was coded for themes using constant comparative analysis. Padgett (1998) defines coding qualitative data as “a process of identifying bits and pieces of information (meaning units) and linking these to concepts and themes around which the final report is organized” (p. 76). Constant comparative analysis is an approach to

coding which begins inductively, becomes deductive, followed by inductive again (Padgett, 1998, p. 77). Padgett (1998) explains, “as themes emerge from initial coding (inductive phase), one goes back over the data to ensure that it is coded in accordance with these themes (deductive phase). As one combs back through the data, new codes often emerge (inductive phase). In analyzing the data from this research project, responses to each question were reviewed together and provisional codes were assigned to all indicators. The process of review and revision of codes was repeated until dominant themes were discovered.

### *Limitations and Biases*

Biases were observed and noted throughout the process. This sample of nine informants was not selected randomly. Informants who chose to participate through recruitment on the NYSSCSW listserv may have had a special interest in discussing clinical work with clients with disabilities. A number of potential informants were located through snowball networking who declined to participate because they did not work with any clients with disabilities. Therefore, the sample size was only a small representation of social workers and offered a glimpse into the views of a select few. A representative sample was not obtained in regards to ethnicity, gender, disability status, or age. Eight out of nine participants identified as female, with only one informant identifying as male. Seven of nine participants identified as white or Caucasian, with only two informants identifying as black or African American. No informants identified as being a person with a disability. These limiting factors prevented generalizability among the greater population of licensed social workers in the NY Metro area.

## CHAPTER IV

### Findings

This chapter contains the findings from interviews conducted with nine licensed social workers from the New York Metro area who work with clients with disabilities in private practice. The interview guide was designed to elicit information regarding participants' experiences working with clients with disabilities by exploring a case study in order to answer my overall research question, *how do experiences working with clients with disabilities shape clinical social workers' perceptions of disability?* The interview schedule is divided into four major areas, each containing multiple probes for assisting with the exploration. These areas are: the clinician's understanding of their work with the client; what guides the clinician's approach to the work; the clinician's transactional language and attitudes with the client; and the clinician's recommendations and observations about working with clients with disabilities. The findings described in this chapter will be organized generally around these headings.

#### *Participant Demographics*

Participants were handed a demographic survey before formally beginning their interview. Open ended questions were asked on the following topics: 1) how do you identify racially and ethnically; 2) how do you identify your gender; 3) disability status; 4) age; and 5)

MSW graduation year and name of institution. Clinicians were reminded that all answers were voluntary and the information would be used to understand who my participants are.

The study sample consisted of eight female and one male social workers. Clinicians ranged in age from 34 to 68 years of age. The mean age was 57, with a standard deviation of 11.35. Seven participants identified as “white” or “Caucasian,” while two participants identified as “black or African American.” Three participants identified as “Jewish,” one identified as “Italian-American,” and one identified as “bi-cultural.”

In the category of school of social work attended, participants attended the following institutions: New York University (two participants), Hunter College (two participants), Columbia University (one participant), Fordham University (one participant), Wayne State University (one participant), Adelphi University (one participant), and the University of California Berkley (one participant). Informants’ total years of post-masters’ experience ranged from eleven to thirty-nine years. The mean was 27.8 years, with a standard deviation of 9.7 years.

In the category of disability status, two clinicians left this question blank. Seven clinicians answered “not disabled;” “N/A;” “no disability;” “none” (reported twice); “no;” and “free.” While no clinician identified as having a disability on the demographic survey, two clinicians disclosed disabilities during their interviews.

Table 1

Participant demographics

<b>Name</b>	<b>Race and Ethnicity</b>	<b>Gender</b>	<b>Disability Status</b>	<b>Age</b>	<b>MSW Year</b>	<b>Institution</b>
Colleen	Caucasian/Italian American	Female	Not disabled	34	2001	Columbia University
Joel	White/Jewish	Male	N/A	52	1988	Fordham University
Kathryn	Caucasian, bi-cultural	Female	No disability	65	1981	Wayne State University
Wendy	White & Jewish	Female	(Blank)	68	1983	Adelphi University
Laurie	Jewish-Caucasian	F	None	68	1973	Hunter College
Sylvia	White	F	No	53	1986	University of California, Berkley
Veronica	Black	Female	Free	60	1976	New York University
Melanie	African American	Female	(Blank)	65	1974	Hunter College
Paula	Caucasian	Female	None	48	1996	New York University

### *Clinician's Descriptions of Their Clients*

Participants were asked to discuss one case study for the duration of the interview. In this section, I will introduce each clinician and the client he/she discussed in the case study. I will outline *bio/psycho/social* information of the clients and what brought him/her into treatment, according to each informant. The bio/psycho/social account is used in mental health assessments and case presentations as a tool to briefly introduce a clinical case. This section may be useful to the reader to refer back to while reviewing the findings and discussion chapters. Both clients' and clinicians' names have been changed in order to protect the identity of all individuals directly or indirectly involved in this study. Furthermore, all client descriptions have been relayed to me through informants only; I had no direct contact with any of the clients discussed in this study.

**Colleen** is a Caucasian/Italian-American, 34-year old female clinician who has been in practice 11 years. She has been working with "Jill" for the past five years. Jill is approximately 40 years old and was diagnosed with Multiple Sclerosis (MS) about five years ago. According to Colleen, Jill's MS has caused the following impairments: "She walks with a cane and has pretty poor endurance, her balance is affected, she has a lot of fatigue, and a limp." Jill also has Type I diabetes, which was diagnosed in childhood. Psychologically, Colleen suspects that Jill experienced un-diagnosed depression growing up. She believes that Jill's family of origin was dysfunctional: "I would say she had some family dynamics, you know typical dysfunctional family, and um, never really got enough support, certainly not enough attunement for her emotional needs growing up." Colleen has diagnosed Jill with Borderline Personality Disorder (BPD), with masochistic features. Colleen sees the development of Jill's personality in relation to her childhood. "There's something, she sort of clings to, so I've picked up things in her

family's life and background of her life. She actually has always had this idea that she really wasn't meant to exist."

**Joel** identifies as a white, Jewish, 52 year old, male clinician. He has been practicing social work for 24 years. Joel's client "Lew" is a 50 year old white, Christian male. Lew looks and acts younger than his age; in fact Joel initially described him as 40 years old, later correcting his error after looking at Lew's chart. Lew is married and has an autistic son, aged 9. He experienced a stroke three years ago, resulting in Guillian-Barre disease, chronic migraines, chronic pain, left side weakness, and hyper-sensitivity to temperature. Additionally, Lew uses a cane to assist in walking. Joel has been working with Lew for the past two years in psychotherapy. His mental health diagnosis is major depressive disorder (MDD), which Joel describes as "moderate to severe." Joel has worked with Lew for the past two years, both in his private practice office and later in Lew's home.

**Kathryn** is a Caucasian, bi-cultural, 65 year old straight female clinician. She has been practicing social work for 34 years. Kathryn requested to call her client "Mary Dinato" to respect her Italian-American heritage. Mary Dinato died in 2005 at the age of 59 due to neuro fibromasarcoma that was in an inoperable place in her pelvis. She was diagnosed with neurofibromatosis as a child which resulted in large lumps all over her skin, and scars from having the lumps removed. At age 14, Mary's right leg was amputated; she wore a leg prosthesis which was uncomfortable at times. Kathryn diagnosed Mary with post traumatic stress disorder (PTSD). Mary was seen for mental health treatment over two distinct treatment periods, both lasting about two years, with three years in between. The first treatment period focused on Mary's desire to increase her social life and obtain a girlfriend; the second treatment

focused on Mary's pain, resulting from her disability. At the end of the second treatment period, Mary became very sick and went into the hospital, where she later died.

**Wendy** is a white and Jewish, 68 year old female clinician who has been practicing for 29 years. Wendy has been working with "Mrs. K" in her home for the past 7-8 years. Mrs. K was approximately 75 when Wendy began working with her, but she initially stated that she was ten years younger. Mrs. K has been married for over 40 years; she experienced several miscarriages and never had any children. She worked as a secretary for a famous musician and business person. Mrs. K told her husband she was 30 when they got married, when she was in fact, 40. The truth about Mrs. K's age was uncovered shortly before Wendy began working with her when her husband asked for her birth certificate to apply for Social Security. Mrs. K has been using a wheelchair for mobility for several years prior to Wendy began working with her, possibly due to spinal stenosis; she also has a kidney disorder which requires "tubes" to carry urine away from her body. Additionally, Wendy believes that Mrs. K has a cognitive impairment. In her mid 70s, Mrs. K was psychologically hospitalized for an acute episode where she was "screaming and carrying on." Mrs. K's home has several barriers preventing her from going upstairs or outside.

**Laurie** is a Jewish-Caucasian female, aged 68. She has been practicing social work for 39 years. Laurie has been working with "Gloria," a 58 year old woman, for the past ten years. Gloria was diagnosed with type I diabetes at age 11, and experienced an amputation due to an accident in 1997. "She was hit by a car, a truck actually. And a drunk driver, and that's how she lost her leg." There is a history of disability and mental illness in Gloria's family; her brother died of ulcerative colitis when he was 18 and her mother had several psychiatric hospitalizations for chronic depression. Gloria worked as a rehab counselor for mentally disabled individuals.



Following the terrorist attacks on September 11<sup>th</sup>, Gloria developed anxiety about crossing bridges. According to Laurie, Gloria was “good” at relationships, and maintained a good relationship with her x-husband and later, x-boyfriend. She was seen by Laurie to treat anxiety and post traumatic stress disorder (PTSD).

**Sylvia** is a 53 year old, white female clinician in practice for the past 26 years. “Alan,” Sylvia’s client, is a 54 year old man who presented to treatment with un-treated lung cancer. Alan is a self-employed business man. He was married, and was going through a separation and divorce during his treatment. He and his wife had a teenage adopted daughter with difficult behavioral issues. Sylvia diagnosed Alan with dysthymia, anxiety, and attention deficit disorder (ADD). “Structure, follow-through, all of those things were very difficult for him.” Alan experienced drawn out hospitalization stays resulting in the ultimate death of both of his parents. While in treatment with Sylvia, Alan sought medical attention for his cancer. He is now in remission.

**Veronica** is a Black, female clinician, aged 60. She has been practicing social work for 36 years. Veronica’s client “John” is a 37 year old, African American, gay man who was diagnosed with Type I diabetes as a child. John had difficulty controlling his disability, resulting in several medical hospitalizations and poor work attendance. At the time that Veronica worked with him, John did not experience any other permanent disabilities related to his diabetes. According to Veronica, John had difficulty socializing. He lived with his elderly parents and adult brother; Veronica felt that John’s parents enabled him to be dependent. Veronica diagnosed John with depression.

**Melanie** is a 65 year old African American, female clinician, in social work practice for the past 38 years. “Jennifer,” Melanie’s client, is a 24 year old woman who was diagnosed with

Asperger's, an autism spectrum disorder, when she was a young child. The presenting issues for treatment were to work on the following areas: "lack of socialization, expressing her thoughts, and limiting herself to utilize her independent skills." Melanie has been working with Jennifer for the past four years.

**Paula** is a 48 year old, Caucasian, female clinician who has been practicing for 16 years. Her client "Erik" is a ten year old, African American boy who has is diagnosed with an attachment disorder and more recently, a thyroid condition. Erik experienced several early attachment issues resulting in developmental delays. In Paula's words, he "defecates in his pants, fingers in his mouth constantly, really can't function. He just cries, can't do transitions, he is just in a constant state of stress." Paula has been working with Erik for the past four years using play therapy in order to help him catch up developmentally.

In the following section, I will examine themes stemming from the first section of questions, the clinicians understanding of their work with the client. As previously mentioned, it may be useful to look back on this preceding section in order to understand the context of the client/clinician relationship.

### **Question area # 1: The Clinicians Understanding Of Their Work With The Client**

In this line of questioning, informants were asked to discuss why they chose a particular client for this study, whether the disability was part of the presenting problem, and when the disability first came up between the clinician and client. If the disability was hidden, clinicians were also asked when the client disclosed the disability. Participants were additionally asked if they questioned or challenged how the client described his/her disability, and whether they found

working with the client more, less or equally challenging in comparison to working with other clients.

The following themes and sub-themes were identified from this line of inquiry. The headings are: 1) who has a disability and what is it anyway?; a) I don't work with clients with disabilities; b) How do *you* define disability?; c) My client doesn't consider himself disabled... and neither do I; 2) variability in reasons for client selection; 3) disability as part of the presenting problem; 4) work with case study client is equally or more challenging than other clients.

Overall I found that participants and potential participants had a more narrow view of disability than the one employed by this study, making it difficult to recruit participants and establish appropriate clients to discuss. The interviews also revealed that the client's disability *was* generally part of the presenting problem, and working with the chosen client for this study was equally, or more challenging than working with other clients on the informants' caseloads.

*Theme 1: Who has a disability and what is it anyway?*

Based on the broad definition of disability employed by this study, I began my recruitment with a belief that most clinicians in private practice had worked with at least one or more qualifying clients with disabilities. I expected to easily recruit a diverse group of clinicians for this study through the methods described in the previous chapter. In actuality, it was both difficult to recruit participants, and difficult for willing participants to choose an appropriate client.

*Sub-theme a: "I don't work with clients with disabilities."*

Several clinicians I reached out to stated that they did not work with clients with disabilities, and therefore declined to be interviewed. In response to a recruitment email, one would-be participant stated:

I have a few obstacles that I think will impede my working with you. The first one may be the definition of the disability. I am presently only working with folks that have psychiatric disabilities. Also, as I think of the last three years, I am working only with the parents, spouses, etc. and not the patient themselves. So I don't think I fit your study.

Both Veronica and Laurie shared that they were unsure if she had a client she could talk about at first when she was approached to participate in this study.

Veronica: "When you first said disability, I said "disability, I really don't see..." and then I said, "that's not true." Then I started thinking and I realized I do have people and patients."

Laurie: "When you said you were working with people with disabilities, I first couldn't think of anyone I work with who's disabled except for the people I work with who have pain."

*Sub-theme b: How do you define disability?*

Of the clinicians who were interviewed for my study, I received many questions regarding *my (the researcher's)* definition of disability, in order to guide the clinician in choosing an appropriate client to discuss.

Sylvia: When you say disability, you describe disability for me. So I know what you're looking for.

Wendy: Tell me what your goal is because I have different people I can choose depending on...

Paula: Just let me know what you're looking for so I can make sure that's the right...

In the cases of Sylvia and Wendy, both clinicians chose an appropriate client for the case.

Paula asked whether an addiction was considered a disability for my study. I faltered at this

question, as addiction is defined as a disability under the ADA's definition. However, I felt it fell under the umbrella of "disabilities clinicians treat," such as mental illness, and therefore should be excluded. Paula eventually chose a child patient who had an emotional disturbance due to early childhood attachment issues, and a thyroid issue.

*Sub-theme c: My client doesn't consider himself disabled... and neither do I!*

Another way that several informants and would-be informants' defined disability was based on the client's *self perception* of whether he/she had/did not have a disability. A clinician who I *did not* interview for this study responded to my recruitment letter by stating, "I do not have any client who self identified with a disability. Best wishes to you." Colleen, who worked with several clients with MS explained that while some of her clients had impairments, not all considered themselves to have a disability:

Some consider themselves disabled because they have MS, and some do not consider themselves disabled. Some have what others might consider physical disabilities, but do not considered themselves disabled. So it's very amorphous depending on the person.

A third finding concerning the definition of disability emerged around the clinicians' disability status. While all clinicians stated that they *did not* have a disability on the demographic survey, Laurie asked whether I considered a particular impairment to be a disability, and Kathryn disclosed during her interview that she had been diagnosed with cancer.

Laurie: I have glaucoma; does that count as a disability?

Researcher: If you think of it as one?

Laurie: No I don't think of it as a disability.

I chose not to point out this discrepancy because the demographic survey is not only optional, but self-reported. However, it is important to note that two clinicians in the study had a history of impairments that could be considered disabilities under the ADA's definition.

### *Theme 2: Variability in reasons for client selection*

I asked clinicians ‘what made you choose this client for the interview?’ in order to further understand what kinds of individuals come to mind when confronted with the term ‘disability.’ No single dominant reason for client selection arose. I discovered that clinicians chose their clients for four main reasons: relevance between mental health and disability, to memorialize a deceased client, based on the client that the clinician felt was most disabled, and seemingly at random.

Two informants chose to talk about a client whose mental health was most affected by his/her disability. Joel explained, “I would say compared to other clients that have disabilities, Lew’s life has been so affected by his disability.” Similarly Colleen stated, “I guess I chose to talk about her because there’s such an interplay between the physical disability and the mental health issues.”

One clinician chose to discuss a client who she thought of as “most disabled.” Laurie: “She seemed the most disabled... I mean I’ve never had people with um, other disabilities. She seemed the most appropriate.” One clinician asked to speak about a client who passed away due to complications related to her disability. In response to my recruitment email, Kathryn stated: “I would like to make my relationship with her count in some way.” One clinician chose a client at random: Sylvia: “I did it in alphabetical order and this was the first name that popped up.”

### *Theme 3: Disability as part of the presenting problem*

The majority of informants stated that the disability *was* part of the client’s presenting issue. Joel felt that Lew’s depression stemmed from his disability: “The disability was a major

part of the presenting problem due to being depressed about the stroke.” Kathryn stated that Mary’s disability was directly related to the presenting problem. “It was part of the presenting problem the first time because she made an odd appearance with-she had-her skin on her face with discolored. She wore matt makeup... she was not getting a girlfriend, and she wanted a girlfriend really badly.” For Melanie, Jennifer’s disability was a large part of her presenting problem because Asperger’s caused difficulty in socializing. “She was very quiet and mute to me initially and was not really comfortable to talk and to open up, and often did not see her sense of self or rather referred through her mother all the time.”

Veronica stated that the disability *was not* part of John’s presenting problem, but went on to say, “But I felt that the diabetes played a huge role in his depression. I felt that the depression and diabetes were hand in hand.” Laurie stated that the disability was *indirectly* part of Gloria’s presenting problem. “She needed to see a doctor and the panic was so great that she couldn’t cross a bridge and she needed to see a doctor. So in that sense, yes.” Only Sylvia stated that the disability *was not* part of the presenting problem for Alan.

#### *Theme 4: Work with case study client is equally or more challenging than other clients*

I was interested in where clinicians rated this client in comparison to work with other clients in their case loads, and why. No clinicians stated that their chosen client was easier to work with when compared to others. Five clinicians stated that working with their client was more challenging in comparison to working with other clients in their case load. Of those clinicians who found working with their respective clients more challenging, two stated that the difficulty was due to personality traits; two stated that it was related to the client’s response to his/her disability, and one stated that it was due to the difficulty of the case.

For Colleen, Jill's borderline features brought up a lot of countertransference which made the therapy more difficult in comparison to other clients.

Colleen: "Way more. I think that's why I talk about her and write about her... Um, I mean because of all that, the countertransference that comes up is incredibly challenging."

Researcher: "What kind of countertransference..."

Colleen: "She uses a lot of projective identification so often I'll feel um, useless, worthless, helpless, hopeless, and um, I have been able to use that with her, luckily, but I can sometimes be when she's really filled with rage, I can often feel totally at a loss. And yes, that's because of her early developmental problems."

Likewise, Laurie found her client more challenging due to her personality. "More challenging in that it's hard to get to anything from her. Was it a reaction to her disability? More to the personality, and I liked her too."

Wendy found Mrs. K more challenging due to her poor insight into her disability and how little she responded to interventions:

Well in some respects it's more challenging because-because of her vagueness about-and I don't know whether she denies that she has-that she's denying, or she doesn't really understand what's wrong with her, or this is a way of, another way of saying it's a kind of denial that she um, you know. 'I don't have to be bothered with the details.' When I first met her, I sort of did my 'Sally social work' you know, 'well we can do this, and we can do that...' [But] every which way to get her out of the house, is resisted.

Veronica explained that working with John was more difficult because it was hard to distinguish reality from the client's distortions about his diabetes.

A little more. Definitely... I was having difficulty in terms what was real, and what was distorted. You know, especially you know, when he would cancel sessions-abruptly-because he was having an attack. And I would wonder how much was this just his way of being resistant and not want to follow through? Or how much was it his condition. And especially because when I offered the telephone sessions, he really wasn't so interested. He would say because he was so sick, and he couldn't talk. So you know, it was that kind of a-how much was manipulation, how much is it a real condition. So, you know I definitely struggled with that.



Paula found working with Erik more challenging due to the complexity of the case. “This is a very difficult case. It’s very entrenched... Because the disruption was so early. I think it was before [age] one.”

Four informants stated that they found working with their client equally challenging. Sylvia explained that her client did not stick out in her diverse case load. “I have an amazingly eclectic private practice so my youngest client is four and my oldest client is 87... He’s just part of the diversity of the day.” Joel stated that he had a lot of respect for Lew. “I would say probably equally [challenging] because I find him captivating and interesting, and so, I think when I felt for him in terms of what he’s got to contend with physically, I think it brought up, at times, feeling very bad for him, [but] I don’t think it’s one of those things where I dread him more...” Kathryn did not directly answer the question, but explained in a later section that she had a lot of respect for her client’s toughness, suggesting that difficulty in working with Kathryn was similarly off-set by her respect and positive countertransference toward the client. Melanie saw her work with Jennifer as different from higher functioning clients, but not necessarily harder. Later, she explained that working with Jennifer is more time-consuming, but does not see it as a burden. “It’s like a lot of extra work but this is why I do the work with her, because that’s what she needs.”

## **Question area #2: Clinician’s Education, Training, and Approaches**

Informants were asked to speak about their theoretical approaches in their general practice, and with the chosen client, in particular. Clinicians also discussed changes (if any) in their approach with the client. More broadly, informants were asked to discuss any training or education and influences that have shaped their approach with clients with disabilities.

The following themes and sub-themes emerged from the interviews: 1) multiple approaches in practice; a) ‘I took a different approach with the client, but kept my orientation in mind;’ b) tailor approach to clients needs (empathetic attunement as the primary element); c) the approach changed over time as the client’s needs changed; d) doing analysis with clients with disabilities is not possible... or takes a long time; 2) varying ways to learn about the client’s disability; a) communication with medical doctors; and 3) many influences guide the work.

Overall, I found that clinicians were oriented toward a number of approaches, but flexible in applying alternative approaches with their clients with disabilities and approaches changed over time as the client’s needs changed. Several clinicians stated that they could not do analytic work with their client. I also found that clinicians learned about their client’s disabilities through a number of methods, with many clinicians stating that they had some prior knowledge about the disability through previous contact with individuals with the same impairment.

### *Theme 1: Multiple approaches in practice*

Clinicians were asked what approaches they found useful in their practice in general and with their client in particular. In their overall practices, informants listed a range of clinical and theoretical approaches that they drew from. Sylvia: “I use a lot of different approaches; I’ve been trained in a lot of different things.” Melanie: “I’m psychodynamic, systems theory approach and cognitive behavioral.” While many clinicians stated that they were primarily “psychodynamic” or “psychoanalytic” in official orientation, all clinicians mentioned other approaches that they were familiar with and regularly used, including (but not limited to): EMDR, CBT, guided imagery, internal family systems, hypnosis, object relations, play therapy, and supportive psychotherapy. In addition to her psychoanalytic orientation, Colleen explained

that she also relies on overarching ego psychology, attachment theory, psycho-education and support, and group modalities.

*Sub-theme a: 'I took a different approach with the client, but kept my orientation in mind'*

The majority of clinicians stated that they used an approach with their client which varied from their stated orientation, but that their stated orientation helped them think about the dynamics of the therapy, including transference and countertransference. Kathryn explained that while she used a supportive approach with Mary Dinato, she was constantly thinking about Mary's history and transferential issues. "When I'm working, I take a historical perspective. And I take a transferential perspective. So, my thinking is, 'who am I to you?' and 'Who are you to me?'" While Veronica used motivational interviewing with John, she explained that she also uses her psychoanalytic training to understand him. "Well my orientation is psychoanalytic. And that is what I wear. That's who I am and how I think and understand things."

Wendy takes a supportive approach with Mrs. K by reminiscing about her past and engaging her in conversations about opera, and other interests. Wendy relies on Erikson (developmental history), and psychodynamic theory in her general practice. She also explained early in the interview that it is important to understand a client's medical condition and how it might affect their mental health. Wendy uses these theories to understand Mrs. K and her relationship with her husband.

I keep trying to work back and forth in terms of the ways-the categories of theory, which is on the one hand, medical-what you need to understand about the medical background of such a person and how it's affecting them, you know. Then I think about the developmental issues and clearly, something happened to her-what's Erikson's last stage? Generativity!

*Sub-theme b: Tailor approach to clients needs (empathetic attunement primary element)*

I asked those clinicians who used a different approach with this client than with the majority of their clients why they chose that particular approach. I found that the clinicians were empathetically attuned to the client's needs and tailored their approach to meet the client where he or she was "at". As I will discuss in sub-theme b, the work with the client sometimes changed over time as the client's needs changed.

Sylvia used an internal family systems approach with Alan. "I chose it for him because just what you are pointing out, that ambivalence piece. You can recognize different parts right away." Veronica chose to use motivational interviewing to help John become motivated in taking better care of his health. She explained that John's health condition was constantly in crisis and she did not feel that she had the "luxury of digging deeper in terms of his unconscious and his rage, which he was totally unaware of."

Melanie used a mixture of family systems and cognitive behavioral with Jennifer, including homework assignments. Melanie explains that she chose this approach with Jennifer's needs in mind:

I knew that she needs to be aware of her thoughts; I know she needs to be able to get things in her mind that she's able to remember; I know she needs to get assignments that she can read; I know she needs to have a visual so she can begin to look at it, think about it, how she can integrate it in the way that she can.

Interestingly, Melanie also explained that she bent the rules with Jennifer, allowing her to text and email her between sessions, which she does not do with other clients. Melanie justifies her boundary shift based on Jennifer's goals in treatment: "Because I'm working with her on how to work with people... And I'm learning the modern way of doing things, I allow her to text me."

Paula explained that she normally plays board games with latency aged children. Due to Erik's developmental delays, she began working with him by playing with dolls and drawing

pictures. “He wasn’t even up to that [playing board games], he was so young developmentally that you couldn’t even bring—he would be the type of kid that if you brought a game and rules for the game, he would have to make up his own rules.”

Joel states that he chose a more supportive approach with Lew due to his disability and limited insight, which makes him slightly lower functioning than other clients. “I tend to have a lot more higher functioning clients that are a little less needing supportive so I think I adjust it a good part because of how he’s been affected by his disability, so yeah I would say that’s a bit different.”

Colleen chose a psychodynamic, psychoanalytic approach with Jill to address her earlier developmental issues. “I’m a firm believer that there’s no other way I could help her if I can’t go back to helping her understand why it is that she feels the way she does.”

*Sub-theme c: The approach changed over time as the client’s needs changed*

In regards to changing work, most clinicians stated that their approach with the client changed as the client’s needs changed. Once again, clinicians were empathetically attuned to the client’s ability to undertake certain approaches at various points in their work together.

Laurie used EMDR, hypnosis, CBT, and psychodynamic approaches with Gloria. EMDR and hypnosis were used early in the treatment to address Gloria’s phobia of bridges and to process her trauma. Later on, Colleen used supportive therapy and CBT to address Gloria’s difficulty in taking risks. “At a certain point when we were working on taking risks, we actually wrote down what risks, uh, she would take, and we made a list of ten and prioritized them and checked up on them each week.” Finally, after about seven years, Gloria finally opened up and became receptive to exploring her past using psychodynamic techniques. Paula’s approach with Erik

changed as he progressed developmentally. “Well I wanted to see when we could use the board games and we did in about a year... And he cheated, you know, what do you call it... unabashedly... And now he can actually play a game without cheating. There is such growth!”

In two cases, the approach with the client changed when the clinician realized that they had initially misinterpreted the client’s needs. As Wendy explains, Mrs. K stated that she wanted to get into the community more often, but became resistant to all interventions that Wendy made. “She would say, ‘You know I’d really like to be able to get out of the house, I love the opera, I used to go all the time, [and] I used to go out for dinner.’ And all of the things she expressed were actually things she could [do], but it took me quite a while to realize she was utterly not gonna.” Once Wendy recognized this, she was able to adjust her approach; more recently, after the relationship developed, Wendy has been gently encouraging Mrs. K to think about doing some of the things she initially stated she wanted.

Similarly, Colleen adjusted her approach with Jill from case management to psychodynamic when she realized that Jill was unable to “take the suggestions and resources that were available to her.” Colleen also expressed that the work changed as the relationship depended. “It’s taken really five years to start to, to feel as though she might be beginning to trust me.” This has allowed her psychoanalytic approach to work more successfully.

Joel, Sylvia, and Melanie reported that the approach with their respective clients *did not* change over time. Although all three clients made progress on their treatment goals, the clinicians felt that the clients’ needs in therapy had not changed in a way that warranted a new approach. According to Joel, the client is in the “same place, but he’s progressed in the sense that’s going to school now.” Alan also progressed by seeking treatment for his cancer, lifting

some of his ambivalence. Jennifer has also made progress in her ability to communicate with Melanie and others.

While Veronica's approach with John also did not change, she hoped it would have moved toward a more psychoanalytic approach had John not suddenly dropped out of treatment after only six months.

*Sub-theme d: Doing analysis with clients with disabilities is not possible... or takes a long time*

A surprising theme emerged in several interviews regarding the use of psychoanalysis with the informant's clients. While no clinician explicitly stated that psychoanalysis is not appropriate with clients with disabilities *in general*, most clinicians stated that psychoanalysis was not appropriate with the client they were discussing, or that psychoanalysis was only possible after many years of therapy using a different approach, such as supportive psychotherapy and behavioral modifying techniques.

Veronica: Psychoanalytic is not appropriate for all patients, and certainly for [John], I didn't think it was appropriate at all. It just wasn't at all-yeah I could talk about his unconscious rage and his self hatred and how acting on himself-but I really at that point felt that we needed to have more of an empowerment, strengths perspective, and figure out how to help him cope.

Laurie: With more people I'm much more-I'm allowed to be more psychodynamic than I am with her. So she has on her own, finally gotten interested in exploring this, and we've been doing that over the last 2 or 3 months.

As previously mentioned, Joel also focused on supportive therapy rather than psychoanalysis with Lew. "With other people, I tend to do a little bit more analysis, a little bit more psychodynamic, or let's say, systems work with families and couples." Kathryn also felt that Mary was not a good candidate for psychoanalysis during the two treatment periods that they worked together. "I certainly couldn't have done any psychoanalysis with her, but I could

definitely help her. I did help her.” Mary’s first episode of treatment was future focused and her second episode of treatment was focused on pain.

Wendy had some concerns about whether Mrs. K was appropriate for general psychotherapeutic approaches:

The hospital, despite its psychiatric expertise, doesn’t know-don’t understand who could be referred for-in general-they miss-they send people to me with cognitive impairments and you can’t do psychotherapy-and people don’t want to do psychotherapy if they’re continuously being asked, ‘well when did this happen and when did that happen.’

Melanie also expressed this theme. “So I think working with special needs people, people need to be very clear. That there’s certain ways you work with them [individuals with Autism] that you wouldn’t work with someone who’s psychoanalytic.” This quote, along with other statements suggests that Melanie did not feel that individuals with Asperger’s were appropriate for psychoanalytic psychotherapy; she rather favored more concrete services, advocacy, and cognitive behavioral approaches.

### *Theme 2: Varying ways to learn about the client’s disability*

Informants were asked if they received any training or education about the client’s disability after they began working with the client. Clinicians received education/training in the following ways: education from the client; prior knowledge through contact with other individuals with similar disability (in clinical setting); and self-education, including researching the impairment on-line or in a book. Several clinicians took more than one approach in educating themselves about the client’s disability.

Gloria was Laurie’s only source of education about diabetes and prosthetics. “No, the education was what she taught me.” Kathryn, who was very knowledgeable about Mary Dinato’s rare disability, learned about it through the client and self-education. “I learned from



her, and I looked things up.” Kathryn mentioned that she was new to the internet at the time, and looking back, believes she could have learned more if she was more familiar with medical online research. Joel had some prior knowledge of Lew’s disability through personal contact, but also learned about it from him. “I knew about Guillain-Barre because I had a good friend who had it so I learned a lot about that... [So] I had some knowledge about strokes, but um he would educate me.”

Colleen, who has previously worked in a medical setting with MS patients recalled, “I learned a lot from the other medical people. And also doing my own research. The MS society, social workers there, colleagues, reading, conferences, that kind of thing.” Wendy also had prior knowledge of Mrs. K’s disability. “I know a little, I’ve had other patients with spinal stenosis. And um, they can be very impaired-physically very impaired, and there can be no correction for it.” Like Colleen and Wendy, Sylvia had previous familiarity with her client’s disability through previous agency experience:

Unfortunately, I’ve worked with a lot of people who have gone through cancer treatment at [the same hospital as Alan]...Uh, life experience, uh, previous client experiences, I’ve worked in hospitals for many years. So I didn’t have to do research.

Melanie also had previous experience working with individuals with Asperger’s and their families. Additionally, she subscribes to a journal magazine on autism put out by a family support group in order to keep up to date with the latest autism news. Veronica learned about John’s diabetes through reading a book she bought at the Salvation Army. “It actually helped me. Um, and I shared it with him that I had gotten a book to help me find out a little more about this.”

*Sub-theme a: Communication with medical doctors*

Speaking to a physician had helped Colleen identify her client's distortion about her limitations. Colleen stated that she was able to use "reality testing" with the client to address the distortion. Reality testing is traditionally an ego function that is often impaired in individuals with psychosis. However, for the purpose of this study, the term "reality testing" will be used as the practice of challenging a client's distortion about his or her abilities and/or level of functioning due to impairment based on medical knowledge which directly contradicts the client's beliefs. Since many individuals with disabilities have on-going health concerns, I decided to start asking clinicians in subsequent interviews whether they were in contact with their client's doctor(s), and if so, how this affected their understanding of the client.

Like Colleen, Veronica also found that by speaking with the doctor and reading a book about diabetes, it helped her distinguish John's limitations from his distortions. In the last part of the interview, Veronica explained that she wished she had had more contact with John's doctor:

I wish I had more contact with the doctor, in terms again of my own education. The doctor was very helpful and knowledgeable and seemed to have a real good sense of the patient. I think it was a real good, comprehensive assessment, I think he was there half a day or whatever. She got to know him very well. She was also, pretty recommending the insulin pump, and she was pretty enthusiastic about it. That helped me think more positively about it because I didn't know a lot about it.

The remaining informants were in minimal contact with their client's doctors. With Mary Dinato's permission, Kathryn requested and received information from her doctors, but did not have any verbal contact with medical providers. Joel was in contact briefly with Lew's doctor, which he found useful. "There was one point I was in touch with his neurologist and um... but now it seems like we're in-sync, so..." Laurie was in contact with Gloria's vocal doctor, who happened to be her cousin, but was not in contact with Gloria's other providers.

Wendy also did not contact any of Mrs. K's doctors. Paula did not explicitly state whether she was in contact with any of Erik's doctor. Of note, Erik was taken to the doctor when his science teacher noticed his eyes were bulging. He was then diagnosed with a thyroid condition.

*Theme 3: Many influences guide the work*

Clinicians reported that they were influenced by many individuals and settings that guided their work with clients with disabilities, including: supervisors, co-workers, teachers, and mentors. Paula was influenced by an experienced professor who helped her understand a difficult client. "He was a teacher, he was brilliant. I mean the kid was like non-verbal, just playing. So I was like 'I've got to bring it into the class,' so I went in, this is what happened, and he saw so many things just in that." Sylvia was also influenced by several professors during her graduate and post-graduate studies.

Wendy was influenced by several individuals: a psychiatrist she worked with in a clinic, a former co-worker who has a disability, and her husband who is a disability advocate. I asked her to give an example of how her husband's work has influenced her: "Just to be more aware-the barriers to access are everywhere. Uh, so you become sensitive-he'll walk down the street and say 'well that ramp doesn't do any good or that's a good ramp.'" Kathryn was influenced by the psychiatrist working with her on Mary Dinato's case. Melanie was influenced by a former supervisor at a psychiatric center who taught her to work from a strengths based perspective. Colleen was also influenced by two former supervisors.

Laurie was influenced by a student with a disability. When asked how the student influenced her, Laurie replied, “In watching my reaction to her.” Joel and Veronica stated that they were not specially influenced by anyone in working with clients with disabilities.

### **Question area #3: Clinician’s Transactional Language and Attitudes with the Client**

Informants were asked to talk about the language they use while discussing the client’s disability, as well as the language the client used to discuss his/her own disability, and whether the language was the same or different. Clinicians were also asked whether their language or the client’s language had shifted over time. Finally, informants were asked if working with the client affected their attitudes toward people with disabilities, in general. Throughout the interviews, clinicians spoke to transference and countertransference reactions unsolicited, both positive and negative.

The following themes and sub-themes were identified after careful review of the transcripts: theme 1) clients discuss their disabilities in multiple ways; a) the client uses medical terms when discussing his disability; b) the client talks about his/her disability using negative connotations; c) the client avoided speaking about his/her disability; 2) the clinician followed the client’s lead with language when discussing the disability unless the language was overly negative; a) I have no idea what language I use with the client to talk about his/her disability; 3) the client’s language did not shift over time; 4) all kinds of attitudes; a) yes, my attitude was shaped by my work with the client; b) participants were willing to talk about countertransference more than attitudes; c) I don’t see people with disabilities differently from anyone else; therefore I don’t have any attitudes toward people with disabilities; 5) I really like the client (positive countertransference).

Overall, this area of the interview revealed that clinicians generally speak about the client's disabilities using the same terminology as the clients so long as the client's language is not distorted. Most clients' language did not change throughout the course of treatment. Attitudes were shaped by work with the client as well as contact with other individuals with disabilities and personal experiences. I also discovered that clinicians more readily shared their countertransference reactions about the client more than general attitudes toward individuals with disabilities; most informants had positive feelings toward their clients and they tended to focus on their client's individual attributes, rather than the disability.

*Theme 1: Clients discuss their disabilities in multiple ways*

Three major categories arose around how the client spoke about his/her disability: the client uses medical terms when discussing his/her disability; the client spoke about his/her disability using negative connotations; and the client avoided speaking about his/her disability. In two cases, clinicians expressed that the language their clients used when discussing his/her disabilities was a defense that the clients employed.

*Sub-theme a: The client uses medical terms when discussing his/her disability*

Four clinicians shared that their clients used medical terms when discussing his/her disabilities. Joel: "I think he always uses it in terms of medical terms. He's always describing it in terms of the condition that he has." Sylvia: "He calls it cancer, lung cancer. He was very direct."

Kathryn explained that Mary's use of medical terms was a defense: "She was very intellectualized, which I think part of that from my own experience now is a way of gaining

respect from doctors... It was a defense herself to become interested in her health. And she defended herself in an interpersonal situation by being as knowledgeable as she could be so her doctors could not look down on her. Or conceal things from her.” While Melanie’s client Jennifer did not understand the term ‘Asperger’s’, she understood the term ‘developmentally delayed’ and was able to explain the premise for her differences with other people. “She says her ‘brain doesn’t function like other people’s but she’s smart.”

*Sub-theme b: The client talks about his/her disability using negative connotations*

Three clinicians explained that their clients used negative language when discussing their disabilities. Laurie explained that Gloria spoke about herself as a ‘klutz’ and has stated that she has not come to terms with being an amputee. Interestingly, Laurie believes that Gloria is starting to come to terms with being a diabetic. Veronica’s client John also speaks about his disability in very negative terms, stating that it is a ‘curse,’ while Colleen’s client calls herself ‘damaged goods’ and crippled.’

*Sub-theme c: The client avoided speaking about his/her disability*

Wendy’s client, Mrs. K avoids speaking about her physical disabilities. “She’s almost like someone out of a Victorian novel... Sort of like just the mention of these things [being in a wheelchair] make her want to swoon.” Likewise, Paula’s client Erik also refuses to speak about his differences from other children; when asked why his fingers were always in his mouth and why he still has accidents, he responds “I’m fine.” Paula believes this response is a defense.

*Theme 2: The clinician followed the client's lead with language when discussing the disability unless the language was overly negative*

For those clinicians whose clients used medical and/or realistic terms to describe their disabilities, clinicians generally used the same language. Several clinicians noted that they followed the client's lead. Joel stated, "Same. "I think I took his lead, yeah. I... refer to the stroke or you know, the neurological pain or the depression. But pretty much following his words and terminology." Sylvia was also direct in naming Alan's disability as cancer. "I'm following his lead. Using his language. However, when a client is extremely negative, Sylvia explores it, but does not follow it. "I have one client right now who says "God is damning me... We'll talk about it, we'll you know, will I call them cursed? No. I don't use that same language with him."

Melanie explained that she avoided using labels when discussing Jennifer's developmental disability, which follows her preference not to use the term 'Asperger's.' She prefers to use the term 'developmentally delayed.' Melanie also explained that she tries to use descriptive language to explain the differences in individuals, while making sure to focus on Jennifer's many strengths. Like Melanie, Paula does not use labels with Erik, but describes his difficulties. "I say things like, 'you know how it's hard for you...' I just describe things. It's very descriptive... We don't plug a name to it because that could be really terminal."

I noticed Wendy used the politically correct term, 'wheelchair user' when describing Mrs. K. When I asked her about this, she explained, "My husband said, 'no, no. People are not bound. They are people who are using a wheelchair.' So it's deliberate." However, Wendy does not talk regularly with Mrs. K about her disability because the client is not interested in discussing it. "I decided I had to make it work for me too. And so, you know, she reads a lot

and she's interested in opera and she's interested in tennis... I've been sort of engaging her around the things she's interested in." So while Wendy is versed in 'people first language,' she took Mrs. K's lead in not discussing her disability.

Similarly, Colleen explained that she generally followed the client's lead when discussing the disability. However, in the case of Jill, the language was too negative and distorted to mimic. "I think I tend to listen for how they refer to themselves. Certainly there are times when their language is so distorted, like [Jill], but other times it's not, it's how they prefer to talk about their abilities or disabilities. So I usually use the language they're using unless it sounds so fraught with negativity that then I want to explore it."

Veronica's language is also different from John's. In a book Veronica read about diabetes, the author described diabetes as a 'condition', rather than a 'disease,' which Veronica found useful in reframing John's experience. "I would raise these issues with him... You have to be where the client is, so it's a balance. I didn't want to get into a power struggle, what I think it is and what he thinks it is, and fight over what his experience is. I just want to kind of open it up in terms of-maybe there could be a different interpretation or experience."

*Sub-theme a: I have no idea what language I use with the client to talk about his/her disability*

When asked what language she used to talk about Gloria's disability, Laurie could not recall. She explained that she had never paid attention to it before:

Laurie: What do I say? Uh, your... I'm not sure [*long pause*].

Researcher: Something that you've never paid attention to?

Laurie: Something that I've never paid attention to.



*Theme 3: The client's language did not shift over time*

Only one clinician noted that the client's language had shifted over time, while the vast majority of informants saw no shift. Veronica explained that while John's language never shifted, she felt a change in her own experience of him: "No, the only thing I would say is my experience of him did not feel so hopeless." Mary Dinato's language also did not shift. Kathryn explained: "She retained her dignity and intellectualization as she talked about the illness." Neither Colleen nor Sylvia noticed any shift in language, either.

Conversely, Joel noticed a slight improvement in Lew's attitude as his depression and pain alleviated. "He'll be very playful about it. I'll say 'how are you?' and he says, 'still breathing!' Or uh, or uh, but he'll always have a smile on his face like he's happy to see me but, 'welcome to my chamber of my situation, basically.'"

*Theme 4: All kinds of attitudes*

I asked informants whether working with their chosen client had influenced their general attitudes toward people with disabilities in any way. In some cases, I modified the question to include the category of disability that the client had. Overall, clinicians identified positive attitudes toward their clients, and stated that they were positively influenced by their experience working with their clients in regards to the larger population of people with disabilities. Informants also noted other individuals with disabilities who influenced them. On the whole, clinicians were more willing to speak about countertransference reactions to clients than their larger attitudes about individuals with disabilities in general.

*Sub-theme a: Yes, my attitude was shaped by my work with the client*

Kathryn and Melanie each found that working with their respective clients helped shape their appreciation for how resilient people with disabilities can be. Kathryn: “I think she set a bar, in terms of how much a person can accomplish, and how, uh brave she was.” Melanie: “I am much more sensitive to them [people with Asperger’s] and I really respect them. They’re very smart people, they’re very intellectual.” Similarly, Joel found working with Lew increased his “respect and thus fear for working with clients with disabilities.” When asked to elaborate, he explained that working with Lew had provided...

Exposure and realizing the humanness of it. Realizing there’s many ways people compensate, uh I’ve seen wonderful things, and um, I guess there’s always the fear of something happening to myself. So I guess it just gives me an option to see that this is just a different domain of human life even if it’s difficult and tricky.

For Colleen, working with Jill helped her notice people with disabilities in the community more.

I think I was just one of those people who didn’t notice people with disabilities. Um, maybe saw them as invisible. Which I think actually is in noticing them and being uncomfortable, and then making them invisible. Whereas now, I’m much more curious. I think I notice-I certainly notice people with disabilities out in the world much more.

*Sub-theme b: Participants were willing to talk about countertransference more than attitudes*

Paula, Laurie, and Wendy answered the question regarding how the work with each of their clients has influenced their attitudes toward individuals with disabilities by discussing their own understanding and reactions to the client. These responses spoke more to the clinician’s countertransference with the client without connecting it to a broader understanding of people with disabilities.

When asked how working with Erik influenced her attitudes toward people with disabilities, Paula answered: “Well, you know he’s been super challenging, so it’s been like dinosaur years watching him making progress. Has he made progress? Yes he’s made

progress.” While I was certainly interested in if, and how the client had progressed, the response did not pertain explicitly to attitudes. Is Paula implying that she learned patience through her work with Erik? If so, how does this influence her attitudes? It is unclear. She quickly steered the discussion toward her desire for Erik to receive more intensive psychotherapy.

Laurie answered the same question by stating, “Well I think I admire her. Difficult though she is, and frustrating as she is because she won’t do the psychodynamic work, she has done very, very well. Um so I admire her.” I prompted Laurie to elaborate by asking, “Has that changed your attitude toward other people with disabilities?” She responded, “I’m not-I guess I haven’t encountered that many people. But maybe it helped me with Donna [Laurie’s student with cerebral palsy].”

Wendy expressed honest frustration with Mrs. K: “Well I guess it manages, after all these years, to be amazing that you could be so-keep yourself in such denial about ‘what’s the matter with you’ and also to limit your world in that way. You know, I’ve had people who struggled against their disabilities to have a full life.”

*Sub-theme c: I don’t see people with disabilities differently from anyone else; therefore I don’t have any attitudes toward people with disabilities.*

Sylvia answered the question regarding her attitudes in a defensive manner that suggested that she did not see people with disabilities as different from other individuals: “I’m sure the research is trying to get at something. When somebody comes in with a disability, it’s not a maker or breaker... It’s just a part of what the person is dealing with. It doesn’t matter what the disability is. It doesn’t matter if they’re missing a leg, I have one of them [client with a missing leg].”

*Sub-theme d: My attitudes were shaped by individuals other than the client*

Throughout the interviews, several clinicians talked about other individuals with disabilities, including other clients, family members, co-workers, and students, and in some cases, compared their reactions to these individuals with their clients. Some clinicians expressed that these individuals had more influence over the respondent's attitudes toward individuals with disabilities than the chosen client did.

Veronica expressed that she has recently become interested in understanding disabilities. "I am interested in the physical, and the psychological, and how they go together. Veronica states that her recent interest in disabilities is influenced by her work with EMDR, family members and friends with disabilities, and own medical issues as she ages. When asked if the client had anything to do with her newfound interest, Veronica answered, "You know, I can't say that. I think it has more to do with me."

Throughout her interview, Laurie discussed a student named Donna who had cerebral palsy and used a wheelchair for mobility. Donna was severely physically impaired, and her speech was slurred due to her impairment. Laurie candidly explained her reaction to finding out Donna would be in her class and meeting her for the first time: "My first reaction was to avoid her. When I saw her the second time, somehow I was more comfortable and I went over and introduced myself and said hello." Later when asked how working with Gloria had influenced her attitudes toward people with disabilities, Laurie stated, "I had a strong reaction to Donna, I do think of her as a person with disabilities, much more than I do Gloria." At the end of the interview, Laurie also expressed that her own experience had shaped her attitudes. "I guess my

attitude is, I was influence by my own experiences. My experience was that I got myself well by working very hard and going out of the envelope, so I assume other people can too.”

Wendy discussed an employee who she supervised at a previous job who had diabetes. This individual helped Wendy understand her own clients better. “So my colleague who has diabetes-it took me a long while to separate her anxiety for her physical condition from her realistic concerns for physical condition. It also sensitized me to my own clients.”

*Theme 5: I really like the client as an individual (positive countertransference)*

Clinicians were more forthcoming with countertransference responses than attitudes, and tended to share countertransferential statements throughout the interview (and not only when discussing attitudes). I included these findings under question area #3 due to the close relationship between countertransference and attitudes. However, these statements tended to be more geared toward the individual characteristics of the client, and not necessarily related to their disability. Many clinicians expressed genuine admiration and respect for their clients.

In the first example, Laurie explains how she was able to use her reaction to Gloria’s voice to move the therapy forward: “It’s just she keeps talking, talking, talking, until very recently... finally at one point I was able to say to her that it was very difficult. I began teaching her relaxation techniques and I told her it was exhausting being with her.” When asked how Gloria responded to the disclosure, Laurie replied, “Very well. I guess we were six or seven years into our relationship so it was timed well. And I’m not... I wasn’t the first person to tell her that, she said. In many ways, *she’s very remarkable*, she could take it.”

Kathryn also had positive feelings for her client:

You know, I respected her, because you know-I did eventually get cancer myself, and I was really tough... But she was very tough. She, with her prosthesis, would climb a

ladder and clean her own gutters... She saved her money and had a house of her own. Um, she had pets. You know, and I just-I just respected her and I-I was a little shocked when I first laid eyes on her, but I got used to it, you know.

DS had a similar sentiment with Lew: "He's an excellent teacher, I love listening to him about science, and I love listening to him-he'll tell me things about history.

#### **Question area #4: Recommendations and Observations about Working with Clients with Disabilities**

Informants were asked whether they had any recommendations for other clinicians regarding working with clients with disabilities, and if anything else came up during the interview that they wished to share. The only theme that was shared across multiple clinicians was the importance of researching and understanding the client's disability, including contact with medical providers.

##### *Theme #1: It is important to understand the disability*

Several informants advised other clinicians to learn the medical side of their client's experience by doing research and consulting doctors.

Veronica: I think it's important to educate yourself about the disability and what it is they're experiencing. To find out more about it. Do some research on it. I think that's really important.

Wendy: You need to be willing to read about disabilities, find a doctor, a psychiatrist who will talk to you. They're not all willing to work with social workers.

Colleen: I think it's really important to find out factually what the physical issues are, because I've seen so much of people's perception being influenced by their mind. So there's so many times, especially with MS where there's such a mind-body connection, I think it's really important-sometimes especially therapists in private practice would never talk to a doctor... But in this case I think it's very important to.

Paula: I guess the biggest thing is you have to be a jack of all trades. So you have to know all the medical things that things could be.

*Theme #2: Additional Advice*

Aside from learning about the disability and having contact with providers, clinicians shared other tidbits of advice and warnings for clinicians. For Laurie, personally experiencing disability was important. “Take care of yourself [*chuckles*]. You know, overcome-have your own experience.” Joel advised clinicians to work from a collaborative approach with clients with disabilities.

I think it’s common sense, but it’s possible that there can be a kind of-you have to watch out of thinking that you’re more intact... I think most clinicians who are willing to work with [clients with disabilities] would probably know that, but unfortunately I’ve seen a lot of situations where people with a non-disability, where there’s a kind of authority or a certain sense of un-equalness in the work. So I wonder if those types of people would sort of infantilize or... I don’t know.

Melanie warned clinicians not to forget social work’s roots in case management by exclusively focusing on psychotherapy, and stressed the importance of providing services in addition to supportive therapy.

I feel social work is losing a lot of its main focus. When it first became a part of this world, the people who got the field moving, they were out there in the community cause they cared about everybody. It was about, everybody needing someone to advocate with them and care about them. And that didn’t necessarily mean they always had to be like, here in my office. And we have lost that.

Kathryn advised clinicians to be open to unconscious feelings that clients have. “I would say being aware of their rage and sadness is really important. Or being open to rage and sadness. And not accepting that ‘little soldier’ at face value.”

## **Additional Observations**

In this section, I will report on observations and themes that emerged from the interviews that were not otherwise reported in the preceding categories. The following themes and sub-themes were identified: 1) Interaction between interviewer and informant; 2) clinicians' new insight. In the first theme, I report on dynamics that emerged between myself (the researcher) and the nine informants interviewed for this study. Several informants suggested that questions in the interview prompted them to reevaluate their work with the client, suggesting that the case-study interview was insightful for both researcher and participants.

### *Theme 1: Interaction between interviewer and informant*

In addition to analyzing the content portion of each interview, I noted several interaction styles, non-verbal cues, and overall impressions in my field notes following each interview. I discovered four major categories of interaction in the interviews: 'the informant as teacher,' 'the interviewer as therapist/consultant/supervisor,' 'the "suspicious" informant,' and 'the "agreeable" informant.' Some interviews fit more than one category, and the roles occasionally shifted throughout the interview.

The 'informant as teacher' was the experienced clinician who wanted to teach me, the social work student, about the approaches to social work practice and theory. Paula began her interview by reading an excerpt from a paper that summed up her understanding of psychotherapy, triggering an interesting, but off-topic conversation. Most of the clinicians took on the role of informant as teacher while discussing their theoretical approaches, though some more than others. In this example, Kathryn tries to teach me about the importance of genograms:

I know you're in a master's program. One of the things that I try to-when I was teaching in a master's program-try to get my students to understand is this [a genogram] is not a



diagram that you draw. That it's a living depiction of the generations of a family that draw out family patterns that are relevant to the client or clients, as the case may be.

I found myself making interpretations, validating and commending informants on their work with their clients on several occasions. I am calling this role 'the interviewer as therapist/consultant/supervisor.' After reviewing each transcript, I noted at least one place in every interview where I interpreted, validated or in some way positively affirmed a clinician's work. In the following example, I clearly took on the role of therapist to the informant:

Interviewer: It sounds like, you know, since she passed away you've had some thoughts about whether she was getting the best treatment or was that the very best hospital... um I can see just from your face, it's a bit emotional just to think about it.

Kathryn: Yeah

Interviewer: And even when you emailed me and said that you wanted to do something to remember her, it was very clear that she's somebody who's made an impact on you. So, um, you know, just to recognize that...

While some interpretations were used in order to check for understanding, upon reflection, many were also made in order to demonstrate my competency as a clinician in my own right. In a less poignant, but more typical example, Colleen described how the relationship between her and Jill changed over time and I offered a clinical term for her role.

Colleen: I think our relationship has changed. In the beginning-it's taken really five years to start to, to feel as though she might begin to trust me. And to begin to um, to begin to even um, believe that someone could care about her. She has a firmly held belief that no one will care, and if no one cares, than no one can help.

Interviewer: So it's a correctional relationship?

Colleen: Yes.

Interviewer: But its taken-it's at a snail's pace.

Colleen: Yes absolutely.

'The "suspicious" informant' was an informant who was suspicious or motivated to find out what my research was "really about." Sylvia and Paula were the two most pronounced suspicious informants. In addition to being suspicious, I also noted that these two informants

were less agreeable to my interpretations. After the tape recorder was turned off, Sylvia engaged me in a conversation about my research, and what “my angle was.”

Similar to the suspicious informant, ‘the “agreeable” informant’ was interested in my research topic. Unlike the suspicious informant, the agreeable informant responded very positively to my study. Most informants engaged me in an informal discussion of my studies at Smith College and/or why I was interested in studying disabilities. Several informants noted that the interview was “interesting” or “thought provoking.”

Interviewer: Ok, is there anything else you want to add?

Laurie: No, but it was very interesting!

Joel was notably the most positive and excited about my study. When I asked him whether he had ever taken a class related to individuals with disabilities, Joel answered “No. Are there classes that you’ve heard of?” This triggered an off-topic conversation in which I disclosed my interest for this study.

Um, we have one [course with disability material] at Smith, but I have a certificate in Disability Studies from CUNY, from the Graduate Center that I did before I came to graduate school, and there is a whole plethora of theories about-it’s not clinically based, these are theories-but I just found it interesting that the two [disability theory and social work practice] don’t seem to mesh even though I think a lot of our social work theories really have a lot in common-you know, client in environment, these kinds of things really work well with the disability model, but I haven’t seen them come together, so...

### *Theme 2: Clinicians’ new insight*

A few informants acknowledged that the interview questions prompted them to examine their work with the client in a new light. When asked about her understanding of disability as an identity, Colleen reflected, “It’s interesting I think I’m-I haven’t thought about this too much so it’s bringing up a lot of thoughts.” As a result of my interview, Veronica obtained new insight into John’s unspoken motivation for dropping out of treatment prematurely. “As I’m talking out

loud, it's making me think 'oh maybe that's why he left, because I wasn't giving into' -I mean he didn't ask 'oh don't charge,' but maybe he has some silent requests or demands that I didn't pick up."

While discussing Gloria's language use around her disability, Laurie reflected that neither she nor Gloria ever brought up or explored Gloria's feelings and experiences working with individuals with disabilities despite Gloria's expressed difficulty accepting her own identity as an individual with a disability. "But that's interesting as I think about it. Maybe we should have [talked about it], or could have."

Joel expressed appreciation for my study in general; after explaining my interest in disabilities, he stated "I think you're points are really good and you just raised my awareness. Like I didn't even know about that-that's really exciting."

## **Summary**

This chapter has presented the findings from semi-structured interviews conducted with nine private practice social workers who have experience working with clients with disabilities. The interview questions revealed that, for this group of clinicians, working with their chosen client was equally or more challenging than other clients on their caseload. Additionally, clinicians were versed in a number of social work approaches, and showed flexibility in applying and changing their approaches to meet the needs of their clients with disabilities. Informants revealed that they learned about their client's disability through a number of methods, including prior knowledge, through speaking with the client, through speaking with physicians, and personal research.

In regards to language use, clinicians indicated that they generally spoke about their client's disabilities using the same terminology as the clients, so long as the client's language is not distorted, and clients' language about the disability did not shift over time. Regarding attitudes, most clinicians revealed positive feelings toward their clients, and tended to focus on individual attributes, while shifting focus away from the disability. Clinicians also revealed that their general attitudes toward individuals with disabilities were shaped by other influences beside their client; this included other clients, family members, co-workers, and students.

A number of unexpected findings were also uncovered. I found that participants and potential participants had a narrow view of disability which made choosing an appropriate client more difficult than this researcher had initially predicted. I also discovered that clinicians were more comfortable discussing countertransference reactions than they were with discussing personal attitudes. A number of dynamics between interviewee and informants were noted. Finally, a few informants discussed how participating in this interview process had prompted new thinking about the topic of disability and their overall work with their client.

In the next chapter, I will compare these findings with the literature reviewed in chapter two. I will discuss limitations of the study and areas of future study. Finally, I will put forth recommendations for social work education and practice resulting from these findings.

## **CHAPTER V**

### **Discussion**

The objective of this qualitative study was to explore the language use and attitudes of clinicians who work with clients with disabilities in order to answer the question, how do experiences working with clients with disabilities shape clinical social workers' perceptions of disability? This chapter will discuss the findings in the following order: 1) key findings, 2) implications and recommendations; 3) limitations; and 4) conclusion.

#### *Key Findings*

The results of this study indicate that clinicians hold a more narrow view of disability than the one employed by this study, suggesting that clinicians may not perceive clients to have disabilities who would otherwise qualify as individuals with disabilities under the ADA's broad definition of disability. Several clinicians had to dwell on their caseload to recognize individuals with disabilities; others suggested that they did not think about their clients as having a disability, even though they are aware of their medical impairment(s).

Throughout the interviews, clinicians had difficulty discussing their client in terms of their disability because they viewed the client as an individual with numerous attributes, in addition to his/her disability. The very idea behind person first language is that an individual is more than their disability; the person comes first. However, by not recognizing a client's disability, a clinician may be closing off the possibility of exploring how disability interacts with

the client's overall identity and may come into play with other client concerns such as relationship issues or mental health diagnoses. This finding suggests that participants do not recognize their clients with disabilities as individuals who are part of a larger disability minority and supports Mpofu and Conyers' (2004) findings.

Clinicians reported that their work with individuals with disabilities was influenced by many individuals and settings, including: supervisors, co-workers, teachers, and mentors. Respondents were also influenced by former contact with other individuals with disabilities. The findings of this study support the literature which conclude that the social model and disability content is excluded from social work curriculums (Leslie, 2008; Gourdine and Sanders, 2002; Gilson and DePoy, 2002), as no clinicians mentioned taking courses in disability studies. This is not surprising given that the majority of clinicians graduated from MSW programs in the 1970's and 1980's, prior to the passage of the ADA. The findings of this study suggest that experience in competent social work practice helped mitigate the gap in disability knowledge for this group of clinicians.

In choosing a theoretical approach to therapy with their clients, participants were flexible in applying alternative approaches with their clients with disabilities and approaches changed over time as the client's needs changed. Many clinicians worked from a strengths based and empowerment perspective, which is in line with the social model of disability. Based upon their many years of experience in the field, it is not surprising that this group of clinicians appeared to have a relatively high level of competence in the differential application of multiple social work approaches in response to their clients' needs.

One finding in the literature that was not supported by the findings of this study was French and Swain's (2001) assertion that there is a power relationship between professionals and

clients. Many clinicians discussed participating in collaborative work with their clients, which blurred the lines between consumer and professional that French and Swain described. As no clinicians received formal education around working with clients with disabilities, it appears that other social work theory and experience have shaped this collaborative environment between client and clinician, including post-masters training, supervision, and other theoretical models. My informants, though not formally trained in disability theory, social model, or people first language, nonetheless muddled through the process along with their clients, and reported that their clients made measureable progress on a number of goals. For example, Sylvia, who was trained in family systems, was able to work collaboratively to assist her client Alan make a decision to treat his cancer. Future research may focus in on how these variables affect clinicians' attitudes and approaches to working with individuals with disabilities.

Informants in the study tended to challenge extremely negative language and attitudes that clients had toward their disability. This runs counter to Swain, Griffiths and Heyman's (2003) findings that clinicians tend to help clients accept and control emotions and constraints caused by their disability. In regards to language use, a critical finding that emerged from this study is that clinicians generally spoke about the client's disabilities using the same terminology as the clients so long as the client's language is not overly negative or distorted. This language, while respectful, tended to focus on medical and descriptive terms. A minority of informants were aware of people first language, though most tended to use it; no clinicians used overtly offensive language during the interviews. This supported Haller, Dorries and Rahn's (2006) study which found a general increase in people first language in the media over time, which transferred to the general public. Of important note, many of the clinicians interviewed in this study began practicing prior to the ADA. The findings of this study also support Arokiasamy

and Strohmer's (1994) assertion that the skill of the therapist is more important than the use of politically correct language in therapy.

Regarding clinicians' attitudes, most informants expressed positive feelings toward their clients and tended to focus on their client's individual attributes, rather than the disability. This tends to support Smith and McCulloh's (1978) findings that female social work students with previous contact with individuals with disabilities hold the most positive attitudes toward individuals with disabilities. The vast majority of my informants were female, and all clinicians mentioned having previous contact with individuals with disabilities. My study also supports Olkin's (1999) assertion that higher levels of education are associated with positive attitudes toward individuals with disabilities.

Several studies in the literature noted the difficulty in ascertaining individuals' true attitudes; my study was no exception. I found that informants were generally more open to discussing countertransference reactions than they were to discussing their attitudes toward individuals with disabilities. This finding was unsurprising given the term 'countertransference' is a psychodynamic term and the majority of informants mentioned they work psychodynamically. Given familiarity and comfort with discussing countertransference reactions, I used this as a tool to better understand clinicians' attitudes. In identifying their countertransference reactions, most clinicians expressed genuine respect for their clients, including the difficulties they had faced and in some cases, overcame in spite of their disabilities. In some cases, these beliefs were expanded to overall attitudes towards individuals with disabilities.

Contemporary psychoanalytic theory, another area of theory which many clinicians expressed familiarity with, has moved toward inter-subjectivity, relational, and a focus on



mutuality in the treatment relationship. In my literature review, I had given a brief overview of these theories and explained why I thought that they were congruent with the social model of disability. Despite a gap in knowledge about the social model, I found that this group of informants (comprised of experienced social workers in private practice) is practicing client-centered therapy that incorporates many of the aspects of the social model. I would speculate that this is in part due to familiarity with these congruent social work theories.

Several clinicians were very curious about my research, and found participating in the interview prompted new thinking about their work with clients with disabilities. This suggests that experienced clinicians are open to learning about disability theory and adjusting their approaches. However, this can only happen with increased awareness and education about these theories. I believe that my research has implications that could further improve the quality of education and clinical practice of social workers who provide clinical services to individuals with disabilities.

### *Implications*

While this self-selected, small group of experienced social workers in private practice may not have offered a representative sample of the larger population of clinical social workers practicing with clients with disabilities, the findings of this study do highlight a number of issues of relevance for training and education. These findings would need further investigation in order to determine their generalizability. The findings of this study point toward the following recommendations:

In the area of social work education, social work programs should include additional education around disabilities, including integration of disability theory into existing social work

theory and practice courses. Additionally, disability content should be integrated into diversity courses in order to encourage clinicians to understand disability as a unique sub-type of diversity.

The following recommendations are put forth for clinicians currently in practice. When working with clients with disabilities, become educated about the client's disability, but *do not* rely solely on the client to educate you; asking the client about his/her disability is OK in conjunction with doing outside research. Additionally, with the client's permission, communicate with physicians and medical providers. In session, be open to exploring the client's experience with his/her disability and explore client's identity as an individual with a disability. In regards to the clinical approach, be flexible in your approach with the client and adjust the approach based on the client's needs as they change. Finally, assist clients in obtaining services and advocating for needs.

### *Limitations*

The sample size of this study was relatively small, with nine informants. Participants were recruited through snowball networking (seven participants) and through email recruitment on the Metropolitan Chapter Listserv of the New York State Society for Clinical Social Work (two participants). All but one clinician currently practices in the New York City Metropolitan area, suggesting that the findings cannot be generalized beyond this region. This study also underrepresented male clinicians, clinicians of color, younger clinicians, and clinicians who are newer to the field of clinical social work. Due to these demographic limitations, the findings of this study cannot be generalized to the entire population of social workers in the country.

Another limitation of this study is the reliance on clinician feedback, without input from the clients who were discussed in this study. A future study could incorporate interviews from both clinicians and clients, comparing the subjective experience of each in long-term therapeutic work together. Furthermore, the positive attitudes and language use by clinicians reported in this study may be in part due to the respondents' desire to "put their best foot forward." In other words, clinicians may answer questions in a way that they think the interviewer wants to hear, or in such a way that makes them look good. This is a genuine limitation of all studies, both qualitative and quantitative. As mentioned in the findings, clinicians tended to steer away from questions that they were uncomfortable about (specifically attitudes). However, clinicians came across as genuine and sincere in discussing their work with their clients. Even when contradicting themselves, clinicians were not perceived as purposefully dishonest.

By focusing on clinicians in private practice, this study excluded the view point of clinicians who currently work in agencies. It is plausible that agencies affect how clinicians practice with clients with disabilities, and interviewing these clinicians could have yielded different findings. The research shows that many individuals with disabilities live in poverty. By focusing on private practice, I inherently focused on a group of clients who likely have increased financial resources such as private medical insurance and/or financial means to pay for private therapy. While no data was collected on the clients' financial standing and insurance, anecdotal data from my interviews suggest that the majority of clients were privileged in this respect. Clients with disabilities with limited financial resources and/or receive mental health services through public insurance were excluded from this study. Future research is needed to explore the therapeutic approaches and needs of clients with disabilities who live in poverty.

By exploring work with clients with broad disabilities, it was difficult to pinpoint preferred therapeutic approaches to working with clients with disabilities. However, this study focused more broadly on disabilities, and part of my findings uncovered varying understanding of this terminology. The findings suggest a number of relevant approaches with this population, with a focus on attunement to client needs. A future study may explore clinical work with individuals with comparable disabilities, such as individuals with spinal cord injuries, or individuals with chronic medical illnesses. Findings from such a study could potentially lead to more specific recommendations for clinicians who work with these particular clients with disabilities.

### *Conclusion*

This study explored the clinical work of nine clinicians who worked with clients with disabilities. Using a case-study format, informants were asked about their understanding of the work, theoretical approaches and education, language use, and attitudes. Overall, the informants interviewed in this study revealed positive attitudes toward individuals with disabilities, which were shaped by past and present work with clients with disabilities and other individuals with disabilities that they had contact with. While clinicians revealed that they practiced flexible, attuned, and competent work with their clients, they also demonstrated a gap in knowledge of disability theory. This paper recommends that such theory be incorporated into future social work education.

## REFERENCES

- Americans with Disabilities Act of 1990, Pub. L. No. 101-336, §2, 104 Stat. 328 (1991)
- Anderson, H. (2005). Myths about “not-knowing”. *Family Process*, 44(4), 497-504.  
doi:10.1111/j.1545-5300.2005.00074.x
- Arokiasamy, C. V., & Strohmer, D. C. (1994). Effects of politically correct language and counselor skill level on perceptions of counselor. *Rehabilitation Counseling Bulletin*, 37(4), 304.
- Brashler, R. (2006). Social work practice and disability issues. In S. Gehlert & T. A. Browne (Eds.), *Handbook of Health Social Work* (pp. 448-468). Hoboken, NJ: John Wiley & Sons, Inc.
- Colker, R. (2005). *The disability pendulum: The first decade of the Americans with disabilities act*. New York: New York University Press.
- Conyers, L. M., Kosh, L. C., & Szymanski, E. (1998). Life-span perspectives on disability and work: A qualitative study. *Rehabilitation Counseling Bulletin*, 42(1), 51. Retrieved from EBSCOhost.
- Daniels, N., Rose, S., & Daniels Zide, E. (2008). Disability, adaptation, and inclusion. In K. Brownlee & A. Cureton (Eds.), *Disability and Disadvantage* (pp. 54-81). Oxford, UK: Oxford University Press.
- French, S. and Swain, J. (2001). The relationship between disabled people and health and welfare professionals. In G. Albrecht, K. D. Seelman & M. Bury (Eds.), *Handbook of Disability Studies* (pp. 734-752). Thousand Oaks, California: Sage Publications.
- Glison, S., & DePoy, E. (2002). Theoretical approaches to disability content in social work education. *Journal of Social Work Education*, 38(1), 153-165. Retrieved from EBSCOhost.
- Goldenberg, I., & Goldnberg, H. (2000). *Family therapy: An overview* (Fifth Edition). California: Brooks/Cole Thomson Learning.
- Gourdine, R. M., & Sanders, T. (2002). Missed Opportunities and Unlimited Possibilities: Teaching Disability Content in Schools of Social Work. *Journal Of Health & Social Policy*, 16(1/2), 207-220.
- Hadley, M. (2008). Relational theory: Inside out, outside in, in-between, and all around. In J. Berzoff, L. Melanao Flanagan, & P. Hertz (Eds.) *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts* (pp. 205-227). New York: Jason Aronson.

- Haller, B., Dorries, B., & Rahn, J. (2006). Media labeling versus the US disability community identity: a study of shifting cultural language. *Disability & Society*, 21(1), 61-75. doi:10.1080/09687590500375416
- Kernberg, O. (1965). Notes on countertransference. *Journal of the American Psychoanalytic Association*, 13, 38-55.
- Leslie, D. (2008). One educator's response to a gap in policy education by offering a social work course on disabilities. *Journal of Human Behavior in the Social Environment*, 18(1), 15-30. doi: 10.1080/10911350802269577
- Mackelprang, R. W., & Salsgiver, R. O. (1996). People with Disabilities and Social Work: Historical and Contemporary Issues. *Social Work*, 41(1), 7-14. Retrieved from EBSCOhost.
- Miller, M. M. (2002). Attitudes of allied health students toward persons with disabilities. *Arete*, 25(2), 12-24. Retrieved from EBSCOhost.
- Mpofu, E., & Conyers, L. M. (2004). A representational theory perspective of minority status and people with disabilities: Implications for rehabilitation education and practice. *Rehabilitation Counseling Bulletin*, 47(3), 142-151.
- Olkin, R. (1999). *What psychotherapists should know about disability*. New York: The Guilford Press.
- Padgett, D. K. (1998). *Qualitative methods in social work research: Challenges and rewards*. Thousand Oaks, California: Sage Publications.
- Smith, N. J., McCulloch, J. W. (1978). Measuring attitudes towards the physically disabled: Testing the attitude towards disabled persons scale (A.T.D.P. Form 0) on social work and non-social work students. *International journal of rehabilitation research*, 1(2), 187-197.
- Swain, J., Griffiths, C., & Heyman, R. (2003). Towards a social model approach to counseling disabled clients. *British Journal of Guidance and Counseling*, 31(1), 137-152. doi: 10.1080/0306988031000086215
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W. W. Norton & Company.
- Zames Fleischer, D., & Zames, F. (2001). *The Disability Rights Movement: From Charity to Confrontation*. Philadelphia: Temple University Press.

APPENDIX A

HSR Approval letter

Smith College School for Social Work

January 1, 2012

Juliette Kennedy

Dear Juliette,

Thank you for your thoughtful email and all of the changes you have made. You are hereby approved. Good luck on your project and Happy New Year!

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.


*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Sincerely,

A handwritten signature in black ink, appearing to read "David L. Burton". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

David L. Burton, M.S.W., Ph.D.  
Chair, Human Subjects Review Committee

CC: Lorraine Tempel, Research Advisor

## APPENDIX B

### Informed Consent Form

Dear Participant,

My name is Juliette Kennedy and I am a master's student at Smith College School for Social Work. I am conducting a research study for my master's degree thesis. My study will examine the changing work of experienced clinical social workers working with clients with disabilities. For the purpose of my study, disability is broadly defined as someone who has a physical or developmental impairment. Data collected will be used in my MSW thesis and in possible future publications or presentations.

You are being asked to participate in an interview lasting approximately 45 minutes. You are being invited because you are a licensed clinical social worker (LCSW) with at least three years post-masters experience. Additionally, you have worked with a client with a disability for at least one year.

Participation in my study may induce mild discomfort while discussing countertransference, language use, and/or other areas of practice. However, you may gain from new insight by reviewing case material, which could potentially benefit future practice. Compensation will not be provided for participation.

I will audiotape and transcribe all interviews. I will make every effort to protect you and your client's confidentiality by removing identifying information from notes, transcripts and other written materials. Aside from me, only my research advisor (RA) will have access to data, but only after all identifying information has been removed. If my research is published or presented, I may use brief illustrative quotes or vignettes that are carefully disguised. All notes, tapes, transcripts, etc. will be kept in a secure location for a period of three years as required by



Federal guidelines. Electronic data will be destroyed when no longer needed. Should I need to keep audiotapes, demographic forms, transcripts and my field notes beyond the three year period, they will continue to be kept in a locked file cabinet drawer in my home office and only I will have access to the key to the cabinet. All materials will be destroyed when no longer needed. It is imperative to mask the identity of clients that are discussed in this interview by using aliases in order to protect their identities.

Participation in my study is voluntary. You may withdraw from the study at any time during the data collection process and you may refuse to answer any question at any point in the interview. You may also request to withdraw your interview in its entirety from the study by emailing me at [jkenned@smith.edu](mailto:jkenned@smith.edu) before April 15, 2012; if you do so, all tapes and transcripts of the conversations will be immediately destroyed. If you have any concerns about your rights or about any aspect of the study, please feel free to contact me at (xxx)-xxx-xxxx or e-mail me at [xxxxxxx@gmail.com](mailto:xxxxxxx@gmail.com); or you may contact the Chair of the Smith College School for Social Work Human Subject Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Researcher: \_\_\_\_\_ Date: \_\_\_\_\_

Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Participant should keep a copy of this form for his/her records.

## APPENDIX C

### Interview Guide

- As you know, I am interested in talking with you today about your experiences working with clients with disabilities. I want you to feel comfortable raising things that come to mind during our dialogue together-even if it seems off-topic or note quite what my questions seemed about. I really want to learn from your experiences, and there may be things that occur to you that I didn't think to ask about. It is imperative that you mask the identity of clients that are discussed in this interview by using aliases in order to protect their identities.

#### **The Clinician's Understanding of their Work with the Client**

- Can you give me a brief bio/psycho/social account of the client and his/her presenting issue?
- What made you choose this client for this interview?
- Was the disability part of the presenting problem? Yes – how? – No: Tell me about it.
- Could you help me understand when the client's disability came up between you and the client?
  1. Possible Probes: Did you bring it up? Did the client? How did this occur? Please describe in detail.
- If the disability was hidden, when did you learn about it?
  1. Possible Probe: how/did the disclosure affect your perception of the client? How did the client talk about his/her disability? Did it change over time?
- Did you question/challenge how the client described his/her disability, or accept it?
- Did you find working with this client to be more/less/equally challenging in comparison to working with other clients? How so?

### **Clinician's education, training and approaches**

- Are there any theories or theoretical approaches that you find useful in your practice in general, and with this client in particular?
- Is this an approach you often use, or did you decide to use it with this particular client?  
Why?
- Has your approach with this client changed over time? If so, how and why?
- Did you receive any training/education (including educating self about client's disability) after beginning to work with this client? If so, how has this influenced your approach with the client?
- Have you been influenced by a particular supervisor, setting, or particular mentor in your work that influenced or guided you or changed your way of working with clients with disabilities?

### **Clinician's transactional language and attitudes with the client**

- Communication is really important in psychotherapy, and the words we chose can make a difference on how we relate to our clients. I noticed you used certain terms when discussing your client, including [insert terms]. I'm curious whether you used this language with your client, or if you used other terms? How did you decide what language to use once you knew about the client's disability? What language did the client use when talking about his/her own disability? Is your language the same as the client's, why/why not?

- Did you notice your language use shift over time? Did you notice the client's language use shift?
- Has working with this client influenced your attitudes toward people with disabilities in general?

**Recommendations and observations about working with clients with disabilities**

- Do you have any recommendations for other clinicians regarding working with clients with disabilities?
- Did anything else come up for you during this interview that you would like to share or discuss before we end?

## APPENDIX D

### Demographic Information

I am collecting the demographic information to get to know who my participants are. Your completion of this survey is voluntary and you may choose not to answer one or more questions by leaving it blank.

1. How do you identify racially and ethnically: \_\_\_\_\_
2. How do you identify your gender: \_\_\_\_\_
3. Disability status: \_\_\_\_\_
4. Age: \_\_\_\_\_
5. MSW graduation year and name of institution: \_\_\_\_\_  
\_\_\_\_\_

## APPENDIX E

### Recruitment Email

Dear potential study participant,

My name is Juliette Kennedy and I am a master's student at Smith College School for Social Work. I am conducting a research study for my master's degree thesis. My study will examine the changing work of experienced clinical social workers working with clients with disabilities. I am sending this e-mail to you because given your professional affiliations, you may be interested in participating in my study.

In order to participate in my study, you must be a licensed clinical social worker (LCSW) with at least three years post-masters experience. Additionally, you must have worked with a client with a disability for at least one year. For the purpose of my study, disability is broadly defined as someone who has a physical or developmental impairment. If you have any questions about the definition of disability in my study and whether a client you have worked with qualifies, please do not hesitate to contact me.

If you choose to participate in my study, I will interview you for approximately 60 minutes. I will ask you about your client and the clinical approaches you took. We can meet at a convenient place and time for you. Prior to our meeting, I will e-mail you a letter of informed consent, and ask that you read and sign it at the beginning of our interview. This letter will inform you of your rights as a participant in my study.

Again, if you have any questions about your eligibility in my research or about my topic, please feel free to contact me. I look forward to hearing from you,

Sincerely,

Juliette Kennedy

Email: xxxxxxx@gmail.com

Phone: (xxx)-xxx-xxxx