How to Find and Contact with your Therapist: People with Disabilities

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Abstract

People with disabilities often face additional challenges when making the decision to enter into treatment in the mental health profession. Although mental health professionals have received training in areas of psychopathology, they may have little or no training or experience working with people with disabilities. Mental health professionals are people who, although they want to be helpful, present with their own biases and fears of disability and medical illness. This paper seeks to help mental health professionals gain a better understand of the person with the disability seeking services from them. It also seeks to give people with disabilities some idea of what to expect from a mental health processional, explains the various types of services offered by the mental health profession and assist the client in finding a therapist right for her or him. The paper addresses some concerns and issues that people with disabilities e and how they can cope with, or resolve these problems.

HOW TO FIND AND CONNECT WITH YOUR THERAPIST

Introduction

Purpose

I have worked in the mental health field for approximately 23 years and have worked with people with various disabilities. Obviously, I work with people with mental illness. Disability goes beyond that to include physical disabilities (e.g. those sustained from injury, medical deformities and other disease). Blindness, deafness, deaf-blind, and orthopedic challenges are what people typically think of as physical disability.

Cognitive disabilities include learning disabilities, autism / aspergers, developmental disorders, cognitive delay and others.

Disability may or may not be confined to medical problems (e.g. heart disease, asthma, diabetes, etc.); however, these problems can lead to or contribute to a disability. For example, many people with diabetes develop neuropathic pain which leads to physical disability. They may develop blindness or other organ complications.

In my work as an advocate, case manager, triage worker, crisis therapist and now mental health / substance abuse counselor, I have come to realize that although there is significant literature do on specific disabilities and what may or may not be the best psychotherapeutic approach to work with each person, there continues to be a reluctance to acknowledge the major issue: How to Connect with the therapist.

Most therapists are people without disabilities. Some may had "hidden" disabilities or medical conditions e.g., mental illness, personality disorders, heart or respiratory problems), however the majority of therapists are not those who use wheelchairs, white canes, dog guides, hearing aids and assistive listening devices, i.e., deaf, blind or orthopedically challenged. They are not people with significant cognitive delays.

The purpose of this paper is (A) to help therapists without disabilities connect with consumers with disabilities; (B), help the consumer with the disability move from being viewed by the therapist as a "person with a disability" to client, patient or consumer — a person; (C) address specific cultural concerns and other issues (e.g., transportation, failure to connect); and (D) Finding the therapist that is right for you and your specific needs as a person, family or couple with a disability or family member with one.

Discussion

Finding Your Therapist

What do all the letters and titles mean in the mental health field? What do these people do, and how can I know with whom to make an appointment? These are questions I am asked many times by most of my clients—regardless of their disability or lack thereof.

In the mental health profession, there are psychiatrists, counselors, psychologists and social workers and case managers. Each of these professionals has specific training in specific areas and then some overlapping qualities.

Psychiatrists generally evaluate, diagnose and medicate. Some use conventional medications while some use nonconventional approaches (e.g. natural remedies, acupuncture). Some also do psychotherapy. It is essential that you determine what you are interested in: Do you want to take medications? Do you want to discuss medications? Do you want to discuss non-conventional issues? And, does the person have certain specialty areas, or provide psychotherapy? If psychotherapy is not part of what the psychiatrist does, he / she will be able to refer you to someone who does.

Counselors

Counselors generally do counseling. They have a wide variety of specialty area and training. Some counselors work with substance abuse issues, others work with mental illness issues / adjustment issues, and some work with both substance abuse and mental illness / adjustment problems. Some counselors work with children while others work with adolescents or adults. Some are trained to work with all or any of these populations. Some counselors do marriage & family (including couples) while others do not. Licensed counselors have been specifically trained in theory and etiology of mental illness / substance abuse. Some are certified or trained for testing which has been approved for their level of education and training. Some offer comprehensive evaluations for a variety of issues including custody, mental illness, substance abuse, etc. while others do not.

The social worker is much the same as the counselor. Although many social workers work in child protection, nursing homes or other agencies, some do provide psychotherapy.

Psychologists do formal evaluations and testing. They are able to diagnose specific cognitive and developmental problems affecting the brain (e.g., diagnose cognitive delay, learning disability, personality disorders, etc.) The psychologist can also diagnose mental illness / adjustment issues. Many offer psychotherapy.

Case managers typically do not provide psychotherapy. They handle case concern, make referrals and connections to appropriate services, and provide support.

Some of these professionals are licensed, some are not. The difference between a licensed professional and non-licensed professional is, essentially, the licensed professional has undergone a significant number of hours of direct supervision by a qualified licensed supervisor, or someone with higher credentials (e.g., Doctorate in the field). Licensed professionals also have passed national standardized testing. They are generally accepted on insurance plans.

Not all professionals will be covered by your insurance plan. If you want to use it, it is essential to learn whether that specific provider is covered by your insurance provider. You can ask the professional, or you can and should call your insurance provider to be certain. This can save you considerable money in the end.

History of Psychotherapy for People with Disabilities

Although there is ample literature on working with people with specific disabilities (e.g., psychotherapy with blindness, deafness, renal disease), there is little in the way of the actual history with people with physical disabilities (Grzesiak & Hicok, 1994). This is largely because psychotherapists who work with people with disabilities (PWD) are generally associated with their area of training or specific title and do not identify with physical rehabilitation.

The area of rehabilitation is a separate field from psychotherapy. It is believed that most people with physical disabilities including blindness and deafness need rehabilitation and are served by their rehabilitation agencies; however, most rehabilitation counselors do not provide psychotherapy.

Although traditionally, rehabilitation has emphasized somatopsychological response (depression, anxiety) and ecological-environmental approaches to how people with disabilities react to the difficulties of their disability (Grzesiak & Hicok, 1994). In other words, issues of accessible housing, transportation, mobility aids and training and specific education and training for employment are the concerns of rehabilitation.

"Early in the history of rehabilitation psychology, this disproportionate focus on the environment appeared to be a reaction against the then-popular psychoanalytic approaches to human behavior that implied "psychopathology" if one had difficulties coming to terms with one's disability" (Grzesiak & Hicok, 1994).

Another reason for the lack of information in history is that the majority of literature focuses on behavioral approaches for people with disabilities. The fundamental differences between rehabilitation medicine and psychotherapy (Diller, Grzesiak & Hicok, 1994) is that rehabilitation medicine is action oriented and psychotherapy is insight oriented.

Although the fields of rehabilitation and psychotherapy remain separate, review of the literature and research indicates that "psychotherapy with the disabled does not differ in any substantive way from psychotherapy with the able-bodied .was (Grzesiak & Hicok, 1994). Therefore, relying on the history becomes germane to the actual treatment and acceptance of people with physical disabilities in psychotherapy.

Connecting with your therapist

Now that you have found the mental health professional with whom you want to work (e.g., ensured they are covered by your insurance, have sliding fee or can accept your payments; that they have sufficient training to address your needs--family, marriage / couples, are culturally competent in compliance with their regulating mandates from their professional code, and can meet with you, how do you connect?

It is essential to explore your specific needs and goals. It is helpful to identify them in the first session with your therapist. Is transportation a possible issue? Does your disability cause you to feel well and able to function on some days, yet interfere significantly with your functional ability on others? What is the policy on needing to cancel or reschedule appointments and how can you and the therapist work with this?

Remember, your therapist may not have a disability (you can ask if you are uncertain). They may have had little or no experience with people with physical or cognitive disability beyond their educational experiences. They may be operating with archaic beliefs about people with PWD. You may well be their educator in this regard wherein the disability applies to you.

Although the advancement of medicine and technology has led to an increase in the survival of people with disabilities, and has greatly improved their ability to function independently, (Padrone, 1994), some professionals may still operate on archaic beliefs and misunderstanding of what you, the person with the disability, has experienced and what you are capable of accomplishing.

You might want to have family, friends or your educational / rehabilitation professionals write letters or contact the therapist on your behalf. Or, you simply need to be assertive and state what it is that you believe is the problem: "I'm depressed", "I'm anxious and worry all the time", "I am having difficulties with my family who try to hold me back", "My husband and I have communication problems", "I am having difficulties with socializing / dating". This will give the therapist some idea of your specific difficulties and how, together, you can overcome them.

It is essential to be open about your disability and not allow the sole focus to be on that disability. The myth is that people with disabilities are depressed and anxious because they are disabled or because of the disability. In reality, you may be frustrated by, anxious about, sad because of, the disability or the problems it is posing, but you are the same as a nondisabled person: people become depressed; people develop anxiety; people develop bipolar disorder or schizophrenia, and a physical or cognitive disability does not cause those conditions to develop.

It is essential that you and your therapist understands that people who are disabled, (acutely or progressively including those born with a disability), experience loss issues. Loss of an ability, (e.g., sight, hearing or physical mobility), or cognitive issues play a big role in the anxiety and depression that a person with a disability may experience. Other loss issues include loss of aspects of oneself; what one perceives she can do or may not be able to do now; how to modify one's life; family's and friend's

reactions which may include loss of friends and family, or difficulty relating, and unrealistic expectations and demands.

Nemiah & Langer (1994) assert that hopes and aspirations must be modified;, income and security for family and self are threatened; one's position in the family and social structure are altered; and, feelings of helplessness and weakness may replace a former sense of strength and competence. This is especially evident for people who develop an acute or progressive disability. However, people who are born with their disability may experience similar realizations when their environment is changed, (e.g., if a child attends residential school and is now faced with a non-structured, often insecure environment in the "real world"; or when a child becomes of age and realizes the need to become more self-sufficient from his / her parents.

"All that forms a person's concept of herself is jeopardized. Loss may involve physical objects and psychological entities" (Langer, 1994). It is essential that PWD be permitted to experience and grieve these losses and be assisted through the grief process of these losses.

Langer (1994) asserts that denial may be a coping strategy if one has sustained a disability. "It may be one of the most challenging and countertransference-provoking reactions to encounter in practice."

Therapists and clients with disabilities need to understand the role of counter-transference and transference in the therapeutic relation. The countertransference is, in part, from the enormity of the loss and the PWD power to evoke the therapist's sense of vulnerability and humanity (Langer, 1994).

Patients with disabilities may find themselves having to explain to mental health professionals what it is like to have their specific disability. Many people without disabilities perceive PWD to be suffering or helpless. They may find accomplishments by PWD to be exceptional or amazing. Although some disabilities are associated with extreme pain, most are not and it is important to make the distinction between illness and disability. Most disabilities do not cause suffering and PWD are able to live functional and fulfilling lives. They date and marry, have children, work, live alone or with others by choice, and achieve many other personal and professional goals.

Cultural issues

People with disabilities comprise a culture or at least sub-culture. It is understood in the mental health profession that mental health professionals are to be culturally competent and sensitive to all cultural differences and diversity (ACA, 2005; APA, 2002; ASW, 2002). All professional codes have similar mandates.

People with disabilities have the added task of helping their therapist understand their world. Similarly, culturally and diverse (CLD) populations have this task. In addition, it is essential to ascertain whether your therapist has training and experience working with your cultural inclusion or is open to learning about it.

Cultural inclusion refers to the cultural with whom you, the client, identifies. All people have an identified culture (e.g., racial-ethnicity, religious, socio-economic or gender and gender preference.) Despite the mandate of the professional codes, not all therapists are able, or have received sufficient training, to work with CLD populations. It is okay and necessary to ascertain that your therapist does and that you will be comfortable in that setting.

For example, some therapists advertise as "Christian counselors". What does this mean? Generally, their counseling approach comes from a biblical or Christian stance. Some, however, are quite accepting of CLD and/or other religions.

Other therapists advertise in other ways using terms such as "existential", "mainline", "eclectic", etc. You need to question the professional to gain an understanding with what these terms mean and their approach to CLD populations.

Hunt, Matthews, Milson & Lammel (2006) did a qualitative study on the issues that lesbians with disabilities face in counseling. "In a survey of 1,925lesbians who responded to the National Lesbian Health Care Survey, Bradford, Ryan and Rothblum (1994) found that 73% of the respondents had seen or being seen by a mental health counselor at the time they completed the survey."

Although a similar study has not been conducted with lesbians with physical disabilities, it seems likely they are being or will be seen by counselors as well.

Hunt, Matthews, Milsom and Lammel (2006) found little in the way of professional literature and no empirical evidence on this subject. The purpose of the study was to begin that process and focus on the experiences of lesbians with physical disabilities.

It is apparent, however, that because previous literature indicates that PWD experience much the same issues and problems that do people without disabilities, there is no significant difference between lesbians with disabilities and lesbians without.

Other similar studies have been conducted in recent years with various racial-ethnic groups including African-American, Native Although American, Hispanic, etc. These cultures tend to utilize the mental health system less frequently, they do not present with significantly different issues than people without disabilities.

It is important to consider the family of the PWD. Family counseling may be helpful in resolving some issues that PWD face with their families. It is essential for the therapist and client to understand recognize that along with the person's with the disability adjustment phase, family members go through an adjustment phase as well. Padrone (1994) and others assert that the family members experience a stress response when a member of the family has a disability. Many of the issues are similar to what the PWD experiences. Therefore, it may be helpful for the therapist to assist family members through loss and acceptance of the person, their own loss issues, and encourage as much self-sufficiency and independence for the PWD as possible.

Specific Issues

Now that you have found your therapist, ascertained he / she is covered by your insurance and questioned their expertise of training and cultural awareness, there may be specific issues with which you must contend:

Transportation

A.

Many people with disabilities must rely on others to take them to appointments, including public transportation or paratransit. This poses some challenges because the friend or family member might cancel at the last minute or simply not show. Paratransit and public transportation is not always reliable or time-consistent. This means the person with the disability may, through little or no fault of her own, miss the appointment or be late.

From the professional's viewpoint, their time is valuable. In some agencies, professionals must account for every hour of their time. Missed appointments can be costly for the professional and create scheduling problems for other clients.

How can you work with these issues? It is important to determine a time that should work for you and give yourself time before and after the session for your transportation needs. This may mean that you spend extra time waiting, however the better you plan, the more likely you will get to your appointments. Professionals have waiting rooms which will allow you to spend some quiet time, read, knit / crochet or listen to music with headphones.

It is important for you to discuss your transportation issues with your therapist. Many will find a work-around solution for times that you are late and/or miss appointments so you can still be seen, avoid no-charge fees and continue with your treatment.

B.

Illness / pain

some physical disabilities present problems for the consumer because of sudden illness or severe pain. Your therapist needs to be aware of this possibility. You, the consumer, need to be honest with yourself and the therapist. So you are in pain today, however is keeping appointment going to be possible? You might even find that by going, your symptoms decrease since stress is highly correlated with pain / illness. If you simply cannot attend, it is important to call your therapist at the earliest possibility and determine what will work for both of you.

C.

Nonverbal communication / communication — People who are blind, deaf and have speech impediments face particular challenges in the communication area. Before you make the appointment, it is helpful for the professional to have an understanding of your communication needs, especially if you require sign language interpreters or have other special needs.

In compliance with the Americans with Disabilities Act (2010) all professional entities that employ over ten (10) employees must make appropriate accommodations to people with disabilities. This means that sign language interpreters must be available to you upon request. Smaller private practice offices may not be able to provide this and are exempt; however, may be quite able to work with you with the use of technology or other means.

Nonverbal communication or lack of eye contact may be problematic for some therapists. Although people who are blind or visually impaired are comfortable without the nonverbal clues, many mental health professionals have been trained to look for them. Therefore, if you are unable to make direct eye contact, it is helpful to simply state that to your therapist. Although nonverbal communication is helpful in the counseling profession, it is not essential to it. Most therapists speak with their clients, and others, every day by phone and have meaningful and helpful conversations. There is no nonverbal communication exchange via phone, yet they continue to help their clients, resolve problems and attend quite well. Once your therapist understands this, the issue of nonverbal communication should be much easier with which to contend.

D.

The office is not wheelchair, or completely wheelchair, accessible — In compliance with the Americans with Disabilities Act (2010), all offices of professionals that employ over ten (10) employees must be accessible to wheelchairs. This includes the ability for you to enter and exit the waiting room and office and be able to use restroom facilities. In smaller practices, the offices may not be wheelchair accessible or completely so; however, the therapist is obligated to have a work-around solution. The person with the disability needs to be open about his / her needs, and it is best to do this prior to your appointment so that your therapist can plan in advance if the location is not fully compliant or you can decide that referral elsewhere would better meet your needs.

E.

Group or family counseling may be difficult or impossible for some people with disabilities. While group or family counseling can be helpful and rewarding, it is not at all helpful if the person with the disability is unable to hear or see communications and no accommodations have been made by the therapist to promote full inclusion and participation.

Likewise, therapists who rely on technology, testing and written homework assignments as part of the treatment need to ensure that the PWD can fully participate. Handouts and other printed information needs to be in an accessible format to people who are blind or visually impaired. It is helpful for you to suggest two possibilities that will work for you. Braille may not be readily available, however a recording or computer format is fairly easy to produce. If these options cannot be utilized for any reason, then it is the professional's responsibility to find ways of accommodating your needs and providing quality treatment that ensures full participation (ACA, 2005; APA, 2002).

F.

We are still not connecting — Connecting with a professional is much like any other connection with people, (e.g., some people relate well to one another, some simply do not). It may be of no fault of yours or the therapist's when a connection is not made. If you feel uncomfortable or that there is no connection, you cannot proceed with therapy and healing. Therefore, it is essential to discuss this openly with your therapist. It may be that you can resolve the problems (e.g. transference or countertransference problems, communication problems, differences of therapeutic expectations). It may be that a referral to another professional will be necessary. In either event, once the problem is discussed and resolved, you can focus on your healing which is, after all, the purpose of seeking mental health treatment.

Conclusion

While counseling or working with someone with a disability poses challenges to both therapist and PWD, it can be a rewarding experience for everyone. The therapist gains a higher understanding and appreciation for people who are diverse, and in so doing, of themselves. The consumer gains a better understanding of herself, her needs, and abilities and is able to formulate goals and complete objectives.

Counseling a person with disabilities means, for the professional, stepping inside the world and worldview of another person who is perceived as somewhat different from you. People with disabilities, while appearing different, have the same desires as do all people: they want to be loved and belong, have power, be free, survive and have fun (Glasser, 1979). To do this, they simply need to determine how it can happen.

Resolving issues of loss associated with the disability, improving connections with family and social networks, determining whether employment or further education is needed or desired, and increasing overall self-sufficiency are ways in which the therapist can help a PWD.

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