THEARAPEUTIC ALLIANCE FOR PEOPLE WITH SENSORY DISABILITIES AND NONDISABLED THERAPISTS: A PHENOMENOLOGICAL APPROACH

ABSTRACT

This is a qualitative phenomenological study conducted to gain an understanding of therapeutic alliance between sighted therapists and adult clients who are blind or visually impaired. It was conducted by telephone interviews of three sighted therapists and seven participants who are blind or visually impaired and who are receiving or have received therapy with sighted therapists. The results indicated that while there were some challenges for both sighted therapists who work with clients with visual impairments, and for the clients who are blind who work with sighted therapists, therapeutic alliance can and does occur, and that the issue of sight or lack thereof did not appear to be the primary factor in determining therapeutic alliance. This study was small and further recommendations would be for a larger study of participants to be utilized as in a quantitative study, which would explore other factors that may interfere with or enhance therapeutic alliance, specific skills, levels of training or knowledge, and communication and/or social abilities of the clients with the visual impairments.

DEDICATION

I would like to dedicate this dissertation to the participants who are blind and visually impaired, and to all people who are blind or visually impaired. It is because of your stories and because of experiences shared by others with visual impairments that this dissertation came to be. It is also because of the experiences I have encountered throughout my life with sighted

therapists and colleagues; however, without your openness, willingness to trust me with your stories and confide in me, this study never could have happened. I thank you from the bottom of my heart. I hope the readers will gain a wealth of information and gain wisdom, understanding, and sensitivity in reading this. I hope they will walk away more self-aware, and possessing the knowledge that people with sight loss are people first with a variety of skills, abilities and desires, just like everyone else, with ever-so-much to give.

SUMMARIES

CHATPER ONE: In summary, it is believed that studying the phenomenon of therapeutic alliance between sighted therapists and people who are blind would lend important information to the mental health and counseling profession as a whole. It is well documented that people who are visually impaired have challenges in their lives that may not be fully realized by people with sight. For example, most appliances are not accessible due to touch pads and lack of raised buttons or speech; unemployment and under-employment are significant issues with the present 70% unemployment rate for people who are blind; many people who are blind live in poverty; people who are blind are at greater risk of trauma and abuse, and there is considerable discrimination in all aspects of their lives.

Conducting a qualitative phenomenon study will elicit the actual voices of the participants. In this dissertation, the reader will gain an understanding of therapeutic alliance between sighted therapists and clients who are blind, therapists' knowledge about blindness and visual impairment, and of the actual experiences of people who are blind.

CHATPER TWO: From the review of the literature, it is clear that people who are visually impaired have been faced with many challenges, longstanding discrimination, social oppression, and stereotypical ideation that continues to persist to 2014. Many have been institutionalized and are continuing to receive their education in residential facilities away from their families. There is presently a 70% unemployment rate for people who are blind, although most are capable of working and desire to do so. Many are living below poverty and have limited access to transportation and other services and resources to meet their social, medical, and financial needs. They do not often receive rehabilitation services, counseling services, or other services to help them cope with loss of vision or general life needs, nor do they often have access to mental health and substance abuse services. In addition, many websites, even in the educational system, remain completely or partially inaccessible. Yet, many people who are blind or visually impaired have managed to be quite successful in life and have been able to meet these, and other, challenges. They have found employment. They have married, are parents, and are well-educated. And many, despite the adversity, are living happy and fulfilled lives.

It is clear that therapeutic alliance is best managed by learning to know and interact with the client as a person first, instead of seeing the blindness first. It is clear that to understand the client, the therapist must enter the client's world by listening, observing, and being willing to ask questions to gain an understanding of who that person is, what his or her experiences in life have been, and what it presently may be. In that way, together, they can develop goals of where the client would like his or her life to become. The therapist may also benefit by placing him or herself in the life of the client (e.g., taking public transportation versus using and owning a vehicle; walking around his or her home without lights and with their eyes closed; trying to

navigate a computer using only screen readers (narrator or voice over) to gain real life experiences of the client. Gaining a cultural awareness can be beneficial when working with clients with vision loss.

CHAPTER 3: The purpose of this study was to learn about the experiences or phenomenon of the interactions between sighted therapists and people who are blind and how those interactions form therapeutic alliance, or, what factors may prevent formation of a therapeutic alliance. A qualitative phenomenological approach was selected as the best method to conduct this study to elicit the information. Two initial groups of participants were studied consisting of Group A, sighted therapists, and Group B, participants who are blind. Each group was interviewed by telephone and encouraged to answer questions openly so as to be able to discuss their experiences.

Data were collected and categorized to look for the core theme. The core theme is what supports the research. This might be thought of as a bicycle wheel with the spokes leading from the center of the wheel to the outer surface and surrounding edge. The center data supports the outer edge as the outer edge supports the center leading back to the center of the wheel. It is critical for the researcher to look for all categories, break each one into themes or patterns, and then develop the final report.

The final report was written in narrative form in the voices of the participants, telling their stories from their perspectives. It is their experiences that tell the story. Does therapeutic alliance occur or does it not? How does it happen or how not? What are the factors that are involved? All of these experiences and the review of existing literature create new possibilities for research, professionals' knowledge, and client enrichment in the counseling profession.

Once the data had been collected, key words which kept reoccurring where looked for in the data (e.g., males, females, blind, visual impairment, sighted therapists, positive experiences, negative experiences, experience with family/parents, individual experience, and specific suggestions.). These became the themes or patterns. These themes, then, were coded and categorized by utilizing a content analysis approach. This, then, brings the patterns back into some meaningful description of the overall experiences of the sighted therapists who work with adult clients who are visually impaired, thereby allowing the researcher to tell the story in a narrative way.

THE FINDINGS

Some of the results of the findings support the literature, some do not. However, it is believed the findings will be useful to counselors by helping them gain a more thorough understanding of clients who are blind or visually impaired. For example, two of the three therapists interviewed in the study indicated that there were some considerable differences working with people who are blind or totally blind versus those with some sight. None of the therapists had any previous professional training or education regarding working with clients with visual impairments. All of them believed having some prior formal training might have been helpful (e.g., they have had some training in other disability areas).

The first research question was can therapeutic alliance happen between a sighted therapist and client? The findings were that therapeutic alliance does occur between sighted therapists and clients who are blind or visually impaired. There are often some modifications in the therapeutic process or thought shifts for both the therapist and client that occur which is discussed throughout the chapters.

The next research question asked: *What is the phenomenon or experience that happens when a person who is blind or visually impaired enters into a client-therapist relationship with a therapist who does not have a visual impairment?* The findings indicated that there was sometimes an awareness beforehand by the therapist that the client was blind or visually impaired. Sometimes the therapist did not know this until meeting the client for the first time. However, no participant was outright rejected; the therapist always attempted to make the participant comfortable. The only unease or discomfort seemed to occur when other sighted individuals (e.g., parents or family) were directly involved in the therapeutic or treatment process.

The next research question asked**:** *Does the client believe that the therapist with sight is able to understand and relate as a person, or, does the issue of sight or lack thereof become an obstacle to the therapeutic alliance?* The findings indicated that the sight or lack thereof did not play a significant role in therapy or therapeutic alliance itself. Some of the therapists made modifications in the techniques they utilized. Some of the participants had some negative experiences, however, could not specifically say it was because of the sight differences and were more likely to believe it was due too general lack of knowledge on the part of the therapist in general training. More detail is discussed in the chapters.

The next research question asked: *How do counselors or therapists with sight believe they relate with and/or are able to form a therapeutic alliance with the client who is blind or visually impaired?* The findings from the therapists indicated they believed they were able to relate well to the participants with visual impairment.

The next research question asked: *Does the sighted therapist's own biases or lack of information impact his or her ability to form an alliance?* The findings indicate the therapists were aware of their biases, however, did not believe that interfered with their work with the client. They did indicate they had some yearning for more professional information in areas of blindness and sight loss specific to mental illness or psychological issues.

The next research question asked: *Is the sighted therapist able to work with the issues of blindness that the client has while maintaining focus on other issues as well (e.g., anxiety, depression, marital or relationship problems, employment, substance abuse, and others that are commonly experienced by people with sight and may or may not be connected to the vision loss?* Both therapists and participants with visual impairment indicated they were able to move easily into the issues that prompted treatment. Again, the only difficulties seemed to be those which involved sighted parents or other sighted family members directly involved in the treatment process.

The next research question asked: *Is the sighted therapist able to discern which issues are directly related and which issues are not?* The sighted therapists believed they were able to make this determination; the participants were not so certain about this. For example, the participants frequently believed that sighted therapists asked too many questions about how they did specific tasks (e.g., ride busses, accomplish daily chores, clean houses, take care of their children, know how to care for their dogs, etc.) and needed to either allow this process to be revealed or needed to do more research or expose themselves to more people who are blind. The therapists indicated they had never received any training with people who had sensory disabilities, nor were they aware of books, training, workshops, or documentation, although all of them were well educated, attended trainings regularly, and were well read. Each professional was aware of books and workshops for other disability populations (e.g., developmental disability, specific mental illness) and had attended these trainings. Each of the therapists believed it would have been helpful if they had been able to have received some training specific to blindness and visual impairment. The therapists who did know a professional who was blind believed his relationship with this person had been helpful to him when working with his clients. He explained that through his interactions and observations of people who are blind, he was able to see how

general chores were done, that people who are blind can and do live full and productive lives, ask for help when and if they needed it, and were not so much different from others. He was able to focus on the client as a person and then only needed to ask specific questions when it pertained to specific content to therapy.

Other findings throughout the study indicate the following:

pT1 reported he worked in the field of mental health with a variety of populations, including developmentally disabled, since 1991. He worked with "less than five (pT1)" clients who identified themselves as having a visual impairment. Two of these clients were totally blind and the others had some sight. Some of this work involved marriage and family; and, some of it involved individual therapy. The clients presented with adjustment diagnoses and were not treated for addictions, although one was believed to have an alcohol disorder. pT2 worked in the field of mental health for 45 years. She was a licensed psychologist. She had worked with two clients, one who identified as being totally blind and the other as partially sighted. In her work with the clients, the client who was totally blind attended all sessions unaccompanied and self-referred. The client who identified as partially sighted attended some of the sessions with her sighted husband; she was self-referred. In one instance, pT2 knew the client was visually impaired; the other she did not know. pT3 had been a licensed psychologist since 1972. He had worked in the prison system and in private practice over the ensuing years. During his work in private practice, he saw no clients who were visually impaired. However, during his work in the prison system, he worked with and evaluated 10 to 12 clients who were blind or visually impaired over approximately 14 years.

All of the participants reported they had friends who were sighted and blind, and felt connected to their blind and sighted friends. Most of them admitted they tended to confide more personal things, especially things having to do with blindness, to their friends who are blind;

however, they feared being judged, or knew they would be judged, more harshly by their blind friends. They reported they tended to have more sighted friends and attributed that, generally, to the fact there were more sighted people than blind. One participant stated she had some sighted friends, however, generally did not feel connected to sighted people.

Six of the seven participants stated it would not matter to them whether their counselor was blind or sighted. They would be most interested in qualification and skills of the therapist and how the therapist could help or relate to them. One participant reported it would make some difference to her because she would be concerned about being judged more harshly by the therapist who is blind. Another participant believed it might make some difference to her because when her sighted therapist pointed out her nonverbal cues (facial changes) it was helpful to her because she was, otherwise, unaware of them or their impact on others.

Five of the seven participants mentioned that they have histories of abuse and have or are receiving treatment for these issues. This abuse has been either from or at the residential school and/or family. This is a significant finding and consistent with the literature that states that 33% to 83% of people with visual impairments have been or are being abused. It is believed these figures are rising.

The participants in the study were not asked about specific mental health or substance abuse diagnoses. One participant reported several psychiatric hospital admissions. Issues included anxiety, depression, family problems, and pain disorders. No addictions were noted. The literature on specific mental illness, criminal history, and addiction yielded little or no

literature for review. pT2 worked with criminals who were visually impaired either at the time of committing the crime or became so during or before their incarceration. The information learned may be helpful to counselors and those who work with this particular population.

The therapists generally knew of the clients' visual impairment prior to meeting them because of the nature of the referral (e.g., it was made through an agency, or because the client had indicated it in some way prior to the visit). In some instances, the clients were accompanied by others (e.g., family or health care workers) and in other instances, they were unaccompanied. This was consistent for the participants with visual impairment (e.g., they generally indicated they had told the therapist beforehand because they needed directions, or for other reasons). If referrals were made, it was from a psychiatrist or physician; generally, most of the participants had made their own connections. None of the participants had ever seen a therapist who was blind, other than possibly rehabilitation counselors. Some stated that they knew therapists who were blind. One of the participants was a psychologist.

When the therapists were asked to describe their feelings upon first realizing they would be working with a client who was blind, the statements were "I was curious . . . it was like having a new toy" (pT1); "I was curious . . . I wanted to know how they lived, how they did this and that" (pT2); "I wanted to help them . . . perhaps maybe I overdid it a little at times" (pT3).

Each of the therapists were comfortable with the mobility aids (e.g., dog guides or white canes). They were not uncomfortable with the eye contact or lack of eye contact and were able to adjust to that. This finding is consistent throughout the research with therapists and participants who did not perceive that their therapists were uncomfortable because of their

inability to establish or make eye contact. However, it is interesting because the issue of inability to make eye contact is widely discussed in the blind community and sometimes causes considerable frustration for those who cannot. The sighted therapists did not believe they interacted differently with their visually impaired clients than to non-visually impaired clients (e.g., speak louder or condescendingly, nor did they believe they addressed the accompanying person versus the client). Again, this finding was consistent, generally, throughout the research. pT2 and pT3 were aware of language differences, however. PT2 was especially cognizant of this because one of her clients was totally blind and had some difficulties with her references to imagery and visual constructs. It took some time for them to develop a comfortable way of communicating in a more verbal descriptive way that was not as inclusive of visual imaging. pT2 noted that the work with her totally blind client had been somewhat slower than with other clients. pT3 became aware that his visually impaired clients were more interested in television shows, for example, which were more verbal in their descriptions (e.g., sports, talk shows versus action shows), and that he needed to use more verbal descriptions in his language as well.

The subject of imagery is interesting because research by Cattaneo and Vicchi (2001), who have conducted a significant amount of research on people who are blind, indicated that people who are blind do have the ability to include imaging in their brain processing skills. It may be there are variations about the images they have, or that some people who are blind can do this and some who are blind cannot, or that there were other complicating factors in this client-therapist interaction. The subject of language differences and barriers and imagery did not present with other participants in the study.

In terms of print materials (e.g., Informed Consent, treatment plans) the therapists read the information to the clients and assisted them in signing the necessary forms. This did not seem to be problematic, although they admitted it took considerably more time. PT3 performed psychological evaluations in this way as well and was unable to do the nonverbal scales because they were not accessible. The therapists chose not to use videos and did not utilize techniques that included writing or readings or drawing. Consistent throughout the research were findings that print materials (e.g., Informed Consents, treatment plans, tests) were not in alternative formats (braille, large print, computerized formats). People who are visually impaired were either read these documents in part, given the documents to take home for someone else to read to them, or the participants did not even know of their existence. This is of real concern. The Americans with Disabilities Act (amended 2010) and all codes of ethics for counselors, psychologists, and social workers mandates that materials, websites, and assessments are to be available in accessible format. People who are visually impaired are not illiterate. They are, generally, able to read and comprehend alternative formats (e.g., braille, or large printed materials, or computerized formats).

Each therapist reported that the issue of blindness or sight loss was discussed by both themselves and the clients at various times throughout the session. pT1 and pT2 worked with these issues of how the sight loss impacted the client more directly than did pT3 because of the nature of his work; pT3 dealt with issues of how the client was being impacted by others and the environment. This finding was consistent throughout the research.

In terms of moving past the curiosity about blindness, the therapist reported they were able to move into the issues that motivated the client to treatment (e.g., if the client was seeking treatment for marriage counseling, they were able to move on to those issues without getting stuck on issues of blindness). Each therapist stated he or she was able to do this by setting aside their own issues of curiosity and trusting that the process would work and that they would get their questions of curiosity answered. The participants with visual impairment reported that what prompted them to find other therapists most often was the former therapists were unable to move past the curiosity phase about how they did things as a person who is blind and move into their presenting issues.

An interesting finding was that when participants engaged in family therapy, difficulties arose. It seemed that the therapists were unable to work within the confines and with concepts of family that involved and included the blind-sighted issues. pT1 and pT2 did work with family and couples involving sighted or high partial spouses but admitted they met only for a few sessions and had met with the visually impaired client beforehand. The participants who had difficulties reported that when the sighted spouse or family and/or parents were involved, the focus was on the sighted person as caregiver or the expectation that the person who was blind could not be the care provider or appropriate role model for children or spouse, and communication and trust (therapeutic alliance) was immediately broken down for all involved.

School attendance consisted of primarily residential school, or a mixture of residential and public school attendance for five out of seven participants. All of the seven participants had

been visually impaired since childhood with some having progressive vision loss over their adult years.

Pt3 shared various experiences and insights within the prison system and there is a strong indication for further research areas within this population.

When asked whether working with a client with a visual impairment was different than working with someone who is sighted, pT1 stated he did not believe so: “Problems are problems, each has a space and is defined.” pT2 believed that working with the client who was totally blind was different because she related to the world and experienced people differently. “The application was different” (pT2). pT2 reported she utilized more touch with her totally blind client (with permission from the client) than she used with sighted clients. For example, she would touch her hand to offer comfort or slow down particular flows of thought that may be going out of control, or help her become unblocked. One participant indicated that CBT is not an ideal therapeutic method of choice because of the writing involved and because there may be real conflict with the therapist’s idea of what are appropriate goals, and the client’s idea of appropriate goals, or even timelines for goal settings. Pt2 indicated that her work with her visually impaired clients seemed to take somewhat longer as well. However, one of the participants did gain her assignments with DBT in braille and reported she is doing well with this; however, if it were not available in braille, she would not be able to fully participate with this modality of treatment. This finding suggests further possibilities for research to explore which therapeutic modalities that may or may not be best evidence practice for people with low to no sight.

SUGGESTIONS FOR PRACTITIONERS

Eye contact. The issue of eye contact is a controversial one, for both sighted and those with visual impairments, for Caucasian and other cultures. Nevertheless, eye contact may be impossible or difficult for people with visual impairments because of eye deformities or artificial eyes. A sighted therapist would do well to not expect eye contact to occur in the usual sense and to go with what does occur (e.g., verbal expressions, voice tones, facial changes). At some point, it may be okay to explore the eye contact.

Ask questions of the client without fear or reservation. However, it may be helpful or necessary to establish rapport with the client before asking the how-do-you-do type questions. People who are blind and visually impaired want to be viewed as people first, not novelties, new toys, or objects of curiosity. Allow the natural process of revelation to come out, then ask for clarification.

Integrate the issues. The person is likely not there because he or she is blind. Although they may well be coping with issues of vision loss and while blindness certainly impacts their lives, attend to the issues that are presented (e.g., problems with family, problems getting a job, problems with alcohol).

Be cognizant of language and language barriers. These may exist because of the lack of sight. Although some people who are visually impaired may not experience any language differences, others might depending on their background experiences and spatial abilities. Language differences may depend on the therapists' degree of reliance on visual utilization or techniques as well. The therapist should speak as he or she normally would, using styles and

techniques that are comfortable and familiar, and then modify as deemed necessary. Seeking the client's input is always helpful.

Be descriptive and verbal about what is happening. For example, if you want to shake hands, express that: "I would like to shake your hand." "I am holding the door on your left." It is also helpful to describe the general environment and surroundings to the client, especially someone who is very low vision or totally blind. Orienting the client to exits, restroom facilities, and water is essential.

Do not assume anything about the client. Every person who is blind is different, has differing skills, abilities, and interests. Get to know the individual client. Each person who is visually impaired has varied intellectual abilities, backgrounds, socioeconomic factors, and family situations, as do sight clients.

Take some time to do some research on how people who are blind and visually impaired live. Although each person who is visually impaired is different, there are similarities as well and some preparation will offset some of the natural curiosity or anxiety humans experience when encountering something new.

Respect the boundaries with dog guides and other service dogs. For example, if the client asks you not to pet, or to allow them to follow, respect that. Do not separate or attempt to separate the person from the dog guide or white cane. Keep in mind the guide or service animal is just that—a working and trained animal to provide a service to the individual.

All print information should be provided in accessible formats. Although reading the information to the client may seem like an acceptable way, it is truly not, unless this is a standard practice for all sighted clients. People who are blind are generally not illiterate. They are quite capable of reading in an alternate way. They are capable of comprehending what they read.

They are capable of writing in an alternate way. It is the therapist's responsibility and obligation to accommodate the client by providing accessible and alternate formats (e.g., braille, large print, audio material, computer formats).

Ask questions to encourage verbal communication. Be specific and clear about identifying emotions. For example, some people who are blind may have experienced trauma and abuse and so may mask emotions or demonstrate emotions differently or inappropriately (e.g., laugh when it would be expected to cry). Be specific by asking, "We are discussing something which might make most people feel sad and you are laughing. Can you explain this reaction?"

Be aware of issues of competency, guardianship in your state. Most people who are blind are not in need of a guardian any more than are their sighted cohorts. These issues need to be openly addressed and discussed with both the client and possibly the client's parents. The adolescent needs to be prepared for young adulthood in the same way as their sighted peers. Blindness is not a reason for maintaining or prolonging guardianship.

Hand gestures may present difficulties for people who are visually impaired. Someone who is totally blind or has little vision cannot see the gestures. They can be distracting or misleading to the person with some sight. Therapists may want to limit their utilization of hand gestures and make it a point to be more verbal in their communication.

Using diagrams, drawings, or written assignments may not be helpful. Therapists who rely heavily on techniques involving journaling or other writing need to explore with their clients who are visually impaired whether this will work for them. It may be that the clients can utilize computers or other means of writing and that these techniques will work quite well. It may be that modifying the techniques to include dialogue will work.

Work with the client to set and establish goals. Sighted people experience the world differently than do people who are blind, and it may be difficult for the sighted therapist to set realistic goals for a person who is blind or visually impaired. For example, a person who is blind may be faced with more unexpected situations (e.g., busses or cabs passing them by, dropping them off in unfamiliar situations, becoming disoriented or lost), which would contribute to feelings of anger or anxiety, and writing a goal of decreasing these feelings to five incidents per month if circumstances occur twice weekly may not be realistic.

CONCLUSION

Overall, the research was consistent throughout. Although there were some differences in the general responses, this was to be expected. The significant findings, however, remained consistent for the therapists and for the participants and with each group combined. There is no significant difference in working with sighted clients and those with visual impairments except the obvious sight loss and basic personal needs associated with that sight loss. There is a need for some training and knowledge of self-awareness and for professionals as well as research on visual impairment. Clients with visual impairments are an underserved population who are hesitant to seek counseling. Furthermore, they are hindered by barriers including transportation, limited financial and insurance resources, and who present with significant needs for counseling. According to the review of the literature, individuals with visual impairments or blindness have higher levels of trauma and abuse, have needs for social skills training, and have higher levels of discrimination, such as stereotyping, rejection, and other difficulties that sighted people either do not face that would prompt them to seek counseling.