Counselling Psychology and Disability

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Abstract

The results of a survey investigating European counselling psychologists' reports on the relationship between counselling psychology and disability suggest that counselling psychologists are engaged with disability in the wide range of their practice; however, such engagement seems less than what one would have anticipated in light of the history of counselling psychology and its connections to aspects closely linked to disability. Qualitative analysis of the data allowed a hierarchical structure of the priorities of respondents keep in mind when working with people with disabilities. *Abilities/Disabilities* was the central emerging notion in which the thematic units *Self/Person*, *Coping/Healing*, *Limitations/Capabilities/Hope*, *Context*, *Ontology/Positivism* were identifiable. Implications include the continuing development of the profession regarding training, adherence to legislation, scientific research, and reflective practice.

Keywords: counselling psychologists; disability; school children; attitudes

Introduction

Disability is a conceptual construct that could be linked to several aspects of counselling psychology, as well as psychology in general. Although some exploration of disability has taken place with respect to aspects of counselling psychology (Davis & Gandy, 1990; Kanellakis, 2000; Prendes-Lintel, 2000; Maki & Riggar, 2004; Bruyère, Van Looy, & Peterson, 2005), it seems that a holistic and systematic approach has yet to be taken.

This paper presents the next step in mapping the relationship between counselling psychology and the concept of disability following a survey investigating counselling psychologists' opinions with regards this relationship.

Method

Instrument & Procedure

This investigation adopted a survey methodology. In 2008, a 10-item questionnaire comprising nine closed questions and a final open text question was constructed. Piloting this questionnaire resulted in its refinement.

Data collection was then facilitated using the online survey website www.surveymonkey.com. Website tools used during the data collection to maximise response rate included reminders and follow-ups. These messages also highlighted to the recipient the breadth of the definition of disability under legislation in relation to the whole range of counselling psychology activities.

To enhance methodological rigour during data collection, the randomisation website tool was applied to the categorical multiple choice responses for the questions 1-9. This tool presents the responses to the questions in different randomised orders for each respondent and so controlling for order effects.

Participants

In light of the European target audience, the sample comprised all chartered counselling psychologists, whose email details were accessible through public records (e.g. The British Psychological Society online register), and the members of the European Association of Counselling Psychology. These two groups did have some overlap. Since the exact number of fully qualified (i.e. at doctoral level) counselling psychologists across Europe (or even in the UK) is not clear, it is not possible to provide accurate figures regarding representative sampling. However, within Europe counselling psychology is most developed in the UK, therefore, the overwhelming majority of the members of the European Association of Counselling Psychology are British, work in the UK or have trained in the UK.

Henceforth, all reference to 'respondents' indicates the counselling psychologists who participated in this research by completing and submitting the online questionnaire.

Analysis

In the process of data cleansing, questionnaires were excluded from quantitative analysis if they contained contradictions or very few replies. Subsequently, the responses of the 98 remaining questionnaires were analysed quantitatively.

In light of the methodological limitations that accompany the pioneering stages of this research, as well as the fact that nine of the questions required the respondents to approximate to given percentage categories, the quantitative analysis figures were treated as rough estimates and no inferential statistics were performed on them.

The responses of all respondents to the open question were analysed qualitatively drawing upon grounded theory principles (Henwood & Pigeon, 1995). Each respondent's answer was broken down into thematic units and numbered accordingly by one of the authors; this was checked by the other author and areas of disagreement were addressed and resolved.

Colour coding was used initially to mark respondents in terms of their primary area(s) of expertise (i.e. physical disabilities, learning disabilities and/or enduring significant mental health problems). In the end this coding was not utilised but its visual nature could have grounded the data in relation to the respondents' experience. In addition to the colour coding, when the researchers were not clear about how to relate an item to the rest of the data, the answer to the open question was reviewed in the context of the rest of the respondent's answers.

The coding and analysis were completed using electronic spreadsheet and word-processing software. Serial versions of the documents enabled the researchers to recall previous stages of the analysis, as did comments either linked to specific data or in terms of a research diary.

Results

Years of professional experience in counselling psychology (inc. training years)

As demonstrated in Figure 1, it is evident that the majority of the respondents had extensive professional experience in counselling psychology. Very few respondents had less than four years training and experience. Approximately one quarter, and therefore the greatest proportion of the respondents stated that they had 11-15 years of professional experience. One fifth of the respondents had 20-30 years of experience, and a small proportion had over 30 years experience.

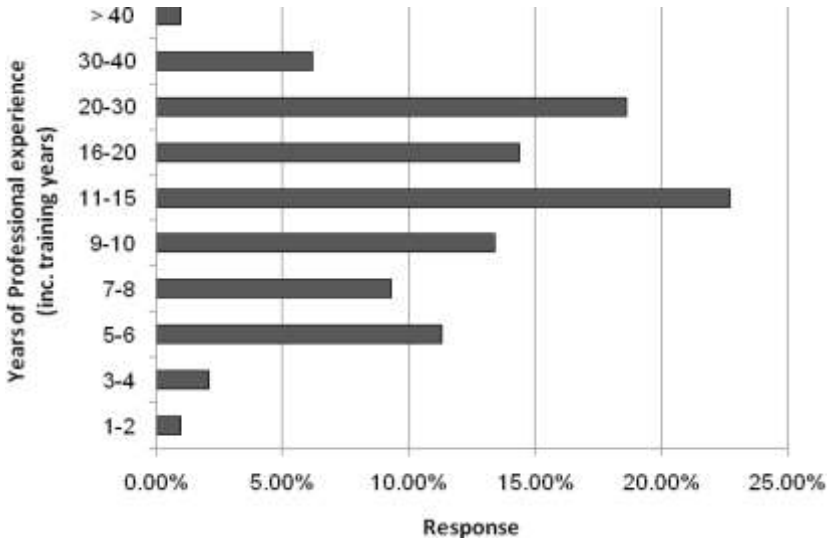

Figure 1 Respondents' professional experience in counselling psychology including training years

Work place

In order of highest to lowest response count, Table 1 shows the various work place settings in which the respondents reported to have worked. Approximately two-thirds of the respondents reported to have worked for some period in

Table 1

Work place settings in which the respondents had experience

Work place	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	5%	Response count
Independent/ Private Practice (excl. EAP[a])	8.1% (5)	1.6% (1)	8.1% (5)	6.5% (4)	0.0% (0)	8.1% (5)	16.1% (10)	12.9% (8)	14.5% (9)	14.5% (9)	9.7% (6)	63.27% (62)
Public mental health hospital/ clinic	8.3% (4)	10.4% (5)	8.3% (4)	12.5% (6)	2.1% (1)	10.4% (5)	14.6% (7)	14.6% (7)	6.3% (3)	8.3% (4)	4.2% (2)	48.97% (48)
School/ University Counselling	2.8% (1)	2.8% (1)	2.8% (1)	2.8% (1)	2.8% (1)	2.8% (1)	5.6% (2)	13.9% (5)	16.7% (6)	27.8% (10)	19.4% (7)	36.73% (36)
Voluntary/ Charity	3.4% (1)	0.0% (0)	0.0% (0)	0.0% (0)	6.9% (2)	6.9% (2)	13.8% (4)	10.3% (3)	13.8% (4)	17.2% (5)	27.6% (8)	29.59% (29)
EAP[a]	4.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	4.0% (1)	0.0% (0)	0.0% (0)	24.0% (6)	28% (7)	40.0% (10)	25.31% (25)
Community organisation/ setting	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	11.1% (2)	5.6% (1)	27.8% (5)	11.1% (2)	33.3% (6)	11.1% (2)	18.37% (18)
Public physical health hospital/ clinic	12.5% (2)	0.0% (0)	6.3% (1)	0.0% (0)	12.5% (2)	12.5% (2)	6.3% (1)	25.0% (4)	12.5% (2)	0.0% (0)	12.5% (2)	16.33% (16)
Private mental health hospital/ clinic	0.0% (0)	6.7% (1)	6.7% (1)	6.7% (1)	6.7% (1)	13.3% (2)	13.3% (2)	0.0% (0)	13.3% (2)	13.3% (2)	20.0% (3)	15.31% (15)
Private physical health hospital/ clinic	28.6% (2)	14.3% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	14.3% (1)	14.3% (1)	28.6% (2)	7.14% (7)
Occupational Health Department/ Service	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	57.1% (4)	0.0% (0)	14.3% (1)	28.6% (2)	7.14% (7)
Forensic, Prison and Probation Services	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	16.7% (1)	16.7% (1)	16.7% (1)	16.7% (1)	33.3% (2)	6.12% (6)
Social Welfare/ Social Services	0.0% (0)	0.0% (0)	0.0% (0)	33.3% (2)	0.0% (0)	16.7% (1)	0.0% (0)	0.0% (0)	0.0% (0)	33.3% (2)	16.7% (1)	6.12% (6)

[a] EAP = Employee Assistant Programme

independent/private practice (excluding Employee Assistance Programmes, EAP) but for most respondents this work accumulated to less than half of their experience portfolio. About half of the respondents reported to have worked for some time in a public mental health hospital or clinic; more than a third reported to have worked in a school or university counselling service; and approximately a third reported to have worked in the voluntary/charity sector. Similar to private practice, these too contributed only a small part of the respondents' experience portfolios. Forensic, Prison and Probation and Social Welfare/Social Services were the least reported work place settings.

Type of disabilities respondents reported to have worked with

Table 2 demonstrates the respondents' experience of working with clients with different types of disability with the most reported type of disability reported first. More than four-fifths of the respondents stated that they had been working with clients with severe and enduring mental illness. Approximately three-fifths reported that they had also been working with people with physical disabilities, but this does not reflect as large a proportion of their clients as people with severe and enduring mental illness. Near half of the respondents reported that they had been working with people with learning/intellectual disabilities, but this once again formed only a small part of their overall experience.

Respondents' disability-related professional experience

Table 3 shows that almost all respondents indicated that they had been working with clients with disabilities. Approximately one-fifth stated that this had been constituting 100% of their work, almost half stated that it had been forming approximately 80% or more of their work, and for

Table 2
Respondents' experience of working with clients with different types of disability

Types of disability	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	5%	Response count*
Severe & enduring illness	16.5% (13)	8.9% (7)	11.4% (9)	7.6% (6)	3.8% (3)	2.5% (2)	8.9% (7)	7.6% (6)	12.7% (10)	12.7% (10)	7.6% (6)	80.61% (79)
Physical disabilities	3.4% (2)	1.7% (1)	3.4% (2)	0.0% (0)	1.7% (1)	3.4% (2)	8.5% (5)	5.1% (3)	11.9% (3)	27.1% (16)	33.9% (20)	60.20% (59)
Learning/ intellectual disabilities	3.6% (2)	0.0% (0)	3.6% (2)	5.5% (3)	3.6% (2)	5.5% (3)	3.6% (2)	9.1% (5)	7.3% (4)	34.5% (19)	23.6% (13)	56.12% (55)

* The percentage responses to this question do not need to add up to 100%, the difference between the total of the percentages and 100% refers to work that is not linked to disability.

Table 3

Respondents' estimated time allocated to types of disability-related work

Type of work	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	5%	Response count
Client work (inc. assessment & treatment)	18.9% (17)	11.1% (10)	17.8% (16)	10.0% (9)	10.0% (9)	14.4% (13)	5.6% (5)	6.7% (6)	4.4% (4)	1.1% (1)	0.0% (0)	91.84% (90)
Training/ Supervision/ Consultancy	1.3% (1)	0.0% (0)	2.7% (2)	2.7% (2)	4.0% (3)	6.7% (5)	16.0% (12)	14.7% (11)	28.0% (21)	22.7% (17)	1.3% (1)	76.53% (75)
Research	0.0% (0)	0.0% (0)	0.0% (0)	2.3% (1)	2.3% (1)	2.3% (1)	2.3% (1)	16.3% (7)	16.3% (7)	48.8% (21)	9.3% (4)	43.88% (43)

Table 4

Respondents' time spent involved in different types of disability-related client work

Type of client work	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	5%	Response count
Individuals with disabilities – one-to-one	7.5% (6)	8.8% (7)	10.0% (8)	5.0% (4)	3.8% (3)	7.5% (6)	8.8% (7)	5.0% (4)	11.3% (9)	17.5% (14)	15.0% (12)	81.63% (80)
Those close to people with disabilities – one-to-one	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	2.0% (1)	8.2% (4)	24.5% (12)	30.6% (15)	34.7% (17)	50.00% (49)
Carers of those with disabilities (professionals or volunteers) – one-to-one	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	10.3% (3)	17.2% (5)	27.6% (8)	44.8% (13)	29.59% (29)
Family work	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	7.4% (2)	25.9% (7)	48.1% (13)	18.5% (5)	27.55% (27)
Individuals with disabilities – group work	0.0% (0)	0.0% (0)	3.8% (1)	0.0% (0)	0.0% (0)	7.7% (2)	3.8% (1)	3.8% (1)	19.2% (5)	46.2% (12)	15.4% (4)	26.53% (26)
Carers of those with disabilities (professionals or volunteers) – group work	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	16.7% (3)	38.9% (7)	44.4% (8)	18.37 % (18)
Those close to people with disabilities – group work	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	5.9% (1)	0.0% (0)	11.8% (2)	29.4% (5)	52.9% (9)	17.35% (17)

about four-fifths it had been forming 50% or more of their work.

About three-quarters of the respondents reported that they had been providing training/supervision/ consultancy in relation to work with clients with disabilities. However, this had been forming only a small part of their overall work in relation to therapy of people with disabilities, with the around half of respondents reporting to have conducted this type of work dedicating between 10-20% of their time.

Finally, approximately two-fifths of the respondents reported that part of their work had been research-based, and of those about half stated that this had been about 10% of their overall activities.

Types of client work

Table 4 shows the types of client work that the respondents reported to have been engaging in, from most to the least frequently reported. Approximately four-fifths of the respondents stated that they had been working with people with disabilities on a one-to-one basis; near half of the respondents reported that they had been conducting one-to-one work with carers of people with disabilities; and approximately a third reported that they had been working on a one-to-one basis with professionals and volunteers providing services to people with disabilities. Also, approximately a quarter of the respondents reported that they had been working in parallel with the families of people with disabilities. Apart from one-to-one work with clients with disabilities, however, where the proportion of time spent providing this type of services varies greatly between respondents, the respondents reported they had been dedicating only small proportions of their time to disability related services.

Distribution regarding age groups

Table 5 shows that approximately four-fifths of respondents indicated that they had been providing services to working-age adults, of which around a quarter stated that that had been 100% of their work. Approximately a third stated that they had been working with teenagers with disabilities, and similarly about a third indicated that they had been working with older people with disabilities. Approximately a quarter of the respondents stated that in parallel with their other work, they had also been working with school age children, around two-thirds of which stated that that had comprised 10-30% of their overall work.

Approximately an eighth of the respondents reported that they had been working with pre-schooling aged children with disabilities, and again this had been forming a small part of their overall work.

Table 5

The distribution of respondents' work across age groups

Distribution regarding age groups	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	5%	Response count
Working age (life) adults	24.4% (20)	18.3% (15)	14.6% (12)	9.8% (8)	1.2% (1)	7.3% (6)	3.7% (3)	3.7% (3)	3.7% (3)	9.8% (8)	3.7% (3)	83.67% (82)
Elderly	5.4% (2)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	8.1% (3)	0.0% (0)	0.0% (0)	37.8% (14)	29.7% (11)	37.76% (37)
Teenagers	5.6% (2)	2.8% (1)	0.0% (0)	2.8% (1)	0.0% (0)	0.0% (0)	0.0% (0)	16.7% (6)	16.7% (6)	44.4% (16)	11.1% (4)	36.73% (36)
School aged children	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	4.2% (1)	0.0% (0)	8.3% (2)	25.% (6)	16.% (4)		20.8% (5)	24.49% (24)
Preschool aged children	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	16.% (2)	0.0% (0)	41.7% (5)	41.7% (5)	12.24% (12)

Table 6

Respondents' reported use of psychological models in their disability-related client work

Psychological models	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	5%	Response count
Cognitive Behavioural	12.1% (8)	1.5% (1)	3.0% (2)	4.5% (3)	6.1% (4)	18.2% (12)	7.6% (5)	13.6% (9)	19.7% (13)	9.1% (6)	4.5% (3)	67.35% (66)
Person centred/ Humanistic	4.2% (2)	2.0% (1)	2.0% (1)	2.0% (1)	2.0% (1)	14.0% (7)	12.0% (6)	12.0% (6)	22.0% (11)	18.0% (9)	10.0% (5)	51.02% (50)
Psychoanalytic psychodynamic	8.8% (3)	0.0% (0)	11.8% (4)	0.0% (0)	2.9% (1)	8.8% (3)	5.9% (2)	17.6% (6)	11.8% (4)	26.5% (9)	5.9% (2)	34.69% (34)
Systemic	0.0% (0)	8.3% (2)	0.0% (0)	4.2% (1)	0.0% (0)	4.2% (1)	4.2% (1)	16.7% (4)	25.0% (6)	20.8% (5)	16.7% (4)	24.49% (24)
Attachment based psychotherapy	0.0% (0)	0.0% (0)	4.3% (1)	0.0% (0)	0.0% (0)	0.0% (0)	4.3% (1)	13.0% (3)	43.8% (8)	21.7% (5)	21.7% (5)	23.47% (23)
Cognitive Therapy	15.8% (3)	0.0% (0)	5.3% (1)	5.3% (1)	10.5% (2)	5.3% (1)	0.0% (0)	5.3% (1)	26.3% (5)	10.5% (2)	15.8% (3)	19.39% (19)
Behavioural Therapy	5.9% (1)	0.0% (0)	0.0% (0)	0.0% (0)	5.9% (1)	5.9% (1)	5.9% (1)	0.0% (0)	35.3% (6)	17.6% (3)	23.5% (4)	17.35% (17)
Social constructionist	0.0% (0)	0.0% (0)	7.7% (1)	0.0% (0)	7.7% (1)	0.0% (0)	7.7% (1)	0.0% (0)	30.8% (4)	7.7% (1)	38.5% (5)	13.27% (13)
Gestalt therapy	0.0% (0)	0.0% (0)	10.0% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	20.)% (2)	50.0% (5)	20.0% (2)	10.20% (10)

Psychological models used when working with people with disabilities

The most-used model, reported by approximately three-quarters of the respondents, was the cognitive behavioural model. The data demonstrates that even though most respondents had been using this model, there is a great variation in the extent that they had been using it.

The next most-used model appears to have been the person-centred/humanistic model, selected by roughly three-fifths of the respondents, and that was followed by the psychoanalytic/psychodynamic model, selected by approximately two-fifths of respondents. Even so, all these models appear to have been used in combination with other models. The systemic model and attachment based psychotherapy were both selected by about a quarter of respondents. The models that were selected least were Gestalt and social constructionism (see Table 6).

Table 7

Respondents' reported estimated use of psychometric tools with clients with disabilities

Distribution	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	5%	None
Psychometrics	11.5% (6)	3.8% (2)	1.9% (1)	7.7% (4)	0.0% (0)	3.8% (2)	7.7% (4)	11.5% (6)	17.3% (9)	15.4% (8)	19.2% (10)	19.39% (19)

Table 8

Respondents' reported use of various communication aids when working with clients with disabilities

Communication Aids	Always/ Most of the time	Frequently	Sometimes	Rarely	Never	Response count
Art (Drawing, Painting, Sculpting, Collage, etc)	3.9% (3)	13.2% (10)	35.5% (27)	19.7% (15)	27.6% (21)	77.55% (76)
Play	3.2% (2)	9.5% (6)	22.2% (4)	17.5% (11)	47.6% (30)	64.29% (63)
Drama	0.0% (0)	0.0% (0)	14.3% (8)	21.4% (12)	64.3% (36)	57.14% (56)
Sign language	0.0% (0)	1.8% (1)	7.3% (4)	12.7% (7)	78.2% (43)	56.12% (55)
Music	0.0% (0)	1.9% (1)	17.0% (91)	9.4% (5)	71.7% (38)	54.08% (53)
Touch/massage	0.0% (0)	1.9% (1)	3.8% (2)	7.5% (4)	86.8% (46)	54.08% (53)

Psychometrics

According to Table 7, approximately a fifth of the respondents stated that they had not been using psychometric tools at all, and a fifth stated that only 5% of their work with people with disabilities had been involving psychometrics. On the other hand, some respondents stated that all of their work with clients with disabilities had been involving the use of psychometric instruments or testing.

Use of communication aids when working with people with disabilities

It appears that only art (drawing, painting, sculpting, collage etc.) had been used a sizeable proportion of the time by the respondents (see Table 8). On the other hand, there were some respondents who reported they had been using art and play 'most of the time' or 'always'.

Priorities

Through grounded theory analysis, the central notion that emerged in the final responses was the concept of *Abilities/Disabilities*. In relation to this, the conceptual thematic units *Self/Person*, *Coping/Healing*, *Limitations/ Capabilities/Hope*, *Context*, and *Ontology/ Positivism* emerged as key priorities (see Figure 2). Please refer to the Appendix for the respondents' quotations supporting the emergence of the following conceptual thematic descriptions.

Defining the conceptual thematic unit *Self/Person*, respondents emphasised conserving their clients' individuality and diversity. Within this thematic unit the respondents focused on the following thematic sub-units:

1. *Client/Individual*. Within which the following priorities were identifiable:
    a. A *Person-Centred* priority related to the respondents themselves (i.e. as the counselling psychologist) and the environment.
    b. The *Emotions* of the clients with disabilities. Pride, shame, anger, frustration, sadness, doubt, joy, and relief are emotions that are identified within this priority. Respondents also referred to their clients' emotions with respect to their *Appearance* and *Lost Abilities*.
    c. The *Behavioural* aspects of clients' experience of living with a disability.
    d. The *Wish* of the client. This appeared to include:
        i. their *Quality of Life* and,
        ii. the *Goals* that the client wishes to achieve, which were also presented as *Requests/Demands*, and linked to the *Needs* of the client.
    e. The *Independence/ Functioning* of the client.

2. *Counselling Psychologist*. The concept of the therapist as a person refers to the human dimension of the profession. Indeed, some of the respondents were themselves disabled. In relation to this priority, the significance of *Awareness* was highlighted. Awareness includes:

    a. The *Impact* of the client's disability on the counselling psychologist and the therapeutic relationship.

    b. *Knowledge* of the particular physical health issues that are linked to the client's disability.

    c. *Vigilance*

    d. Personal perception regarding *Oppression*.

    e. *Personal Assumptions*

    f. The *Movements* of the counselling psychologist during sessions.

3. *Identity,* which included the *Ideology/Values* regarding social justice.

4. *Cognition* of the client and the counselling psychologist.

5. *Phenomenology* in relation to the contact of the counselling psychologist with the client. The respondents focused on their clients' and their own *Sense-Experience,* of which important components were:

    a. The perception of *Life*

    b. *Perceived Difficulties*, including the *Financial* difficulties associated with having a disability.

    c. *Time*, where they prioritised the *Present* with respect to how it had been developed by the *Past*. At the same time, the direction was maintained towards the *Future* of the therapeutic relationship.

Another of the respondents' thematic unit priorities was *Coping/ Healing*, which related to the ability of people with disabilities to deal with difficulties in their own way. Conceptual thematic sub-units that emerged were:

1. *Acceptance* of the disability, by the client as well as by the counselling psychologists. This was a requirement for *Coping/Healing*. Associated with *Acceptance* was:

    a. The need for experienced *Humanity*, including within the therapeutic relationship.

b. The *Adjustments* of the people with disabilities, the counselling psychologists themselves, and the whole environment regarding the existing challenges.

2. The concept of *Loss*.

3. *Change*

4. The increase in *Control*, of which people with disabilities are deprived.

Forming the part of the conceptual thematic unit *Limitations/Capabilities/ Hope*, the respondents did not ignore the *Limitations* that their clients experience, as well as those that characterise the respondents themselves and the available services. As a consequence of these *Limitations* there was a *Sense of Uncertainty* and *Risk*. Within this same conceptual thematic unit but besides *Limitations* the respondents also noticed their clients' *Capabilities/Hope*, which allowed the Strengths of their clients to unfold.

Context is another conceptual thematic unit that emerged in the respondents' answers as a key priority. Important dimensions within this thematic unit for the clients, and therefore for the respondents, were *Breadth*, *Social Context*, *Statutory Agencies*, *Social Action*, *Equality/Non Discrimination*, *Social Justice*, and *Financial Context*.

1. *Breadth*

2. The *Social Context* in which the clients with disabilities live. Regarding this thematic sub-unit respondents also referred to:

   a. *Organisational Context*

   b. *Stigma*

   c. *Systems.*

      i. This was seen to impact on the *Inclusion/Exclusion* of people with disabilities, and a connection was made with *Access*.

      ii. The *Dynamics* that influence other changes.

   d. A *Relational* dimension which includes *Relational Complexity*, and *Intrapersonal Relationships*. The respondents compared the type of relationships that they develop with their clients with disabilities to other human relationships:

      i. *Parents/Young Children* and the *Protectiveness* that comes with parenthood

      ii. *Couples*

iii. *Peers*

iv. *Family*

v. *Carers*

They also refer to *Attachment* that develops, and to *Authenticity* – an important characteristic of relationships.

3. *Statutory Agencies*, especially *Schools*.

4. *Social Action*. Major concepts within which were *Legal*, *Intrapersonal Care*, *Political*, and *Helping*. The respondents appeared to help their clients through:

   a. The *Therapeutic Relationship* – a broad key concept that fitted within *Helping*. Important priorities of the respondents were:

      i. The *Communication* between the clients and their families as well as with the counselling psychologist. Important dimensions included:

         - *Information*

         - *Expression* or not of the clients' concerns. The concept of *Expression* comprised the *non-Explicit* information from the respondents to their clients.

         - *Clarity*

         - *Communication Restraint*

      ii. The *Sharing* of experience through the therapeutic relationship.

      iii. *Appreciation* of the individual in his/her own right. This priority appeared to be based upon the foundations of holistic *Respect*:

         - Towards the *Client* as a person.

         - In relation to the *Client's Priorities* and in collaboration with the client, and not to that of the counselling psychologist.

         - The *Sameness/ Difference* of each individual in relation to others.

         - *Normalisation*, which was linked to *Alternative/ Adjustments.*

      iv. *Care* included the *Ethics* of the respondents as responsible professionals, which came with:

         - *Responsibility*

- *Competence and its limitations*
- *The necessary Training*

v. *Empowerment* of the client

vi. *Collaboration* within the therapeutic relationship

vii. The necessary *Trust/Safety*

viii. The *Ending* of the intervention

b. *Assessment/Treatment* was an important element of helping clients in that of good *Assessment* was followed by the *Treatment* of people with disabilities. Important factors included:

i. The *Model* on which the respondents had been basing their work with people with disabilities. It appeared that models were chosen based on the evaluation of assets rather than deficits.

ii. The *Efficacy* of treatment, in which contributed both the *Creativity* of the respondents and *Practice-based Literature*.

iii. *Cure* or its absence.

iv. The *Motivation* of all parties

c. *Teach/Learn* was presented as a multi-directional process within which the client, the therapist, and the family shared knowledge.

d. *Assist/Facilitate/Enable/ Support*, which included concept of the required Resources,

e. *Dependence*

5. *Equality/Non-Discrimination*,

6. *Social Justice*,

7. *Financial Context* that affects people with disabilities

The key conceptual thematic unit *Ontology/Positivism* focused on the observations themselves and emerged as the result of attendance to more claims about facts than to the facts themselves. This thematic unit included the following conceptual thematic sub-units:

1. *Part-Whole*. An important dimension present in the respondents' replies was that of the *Whole* and its components. This also contained the concepts of *Degree*, and of *Good/Bad*.

2. *Understanding* included the *Reasons* explaining the client's difficulties.
3. *Core* referred both to the essence as well as the centre of relationships and also to the pain experienced by people with disabilities.
4. Respondents also attended to *Valuing* the individuality of their clients
5. *Physical/Emotional*
6. Associated *Actions* were highlighted based on the ways in which different individuals perceive events.
7. *Health/Illness*

Discussion

Limitations and recommendations for future research

Before presenting the tentative conclusions from this study it first seems prudent to acknowledge its limitations. Of the inherent limitations in the survey methodology used here, the main consideration with regards the present data is that the responses collected are more likely to be from those members of the larger population who considered the research topic to be important; consequently, the likeliness of bias within the data is increased. Efforts to reduce this factor included sending several reminders on different days and times, thus targeting the different email responding patterns of counselling psychologists (this was one of the strengths of the survey software used). However, it was evident during data collection that detailing the significance of the topic in these reminders had the effect of influencing the responses, as well as the response rate; a maximum of three reminders were sent, but it is likely that by the third reminder neither the response rate nor the influential effect to the content of the responses would be further enhanced. As the quantitative questions were mostly linked to reports of their practice, such emails might have enhanced the accuracy of the respondents' reports but they might have skewed their responses to the open question about their priorities. Consequently, these biases must be kept in mind when considering the patterns in the data. A further limitation relating to the sampling procedure was that the free software used was unable to count the number of declines to participate, when the respondents were close to 100.

Regarding the limitations relating to the quantitative data collected, it has been acknowledged above that findings can only be treated as guidelines since respondents were required to approximate their answers to given percentage categories. Future research could address this issue, potentially by further emphasising to respondents at data collection that the percentage categories have been designed as tools to create an ordinal scale (thus, numbers should be treated as

rounded approximations). Alternatively, the questions could be presented in a different format.

A further limitation of the questionnaire design is that the survey software could not total the respondents' percentages as they input them. Consequently, respondents were required to total their own cumulative answers and in the stage of data cleansing several errors were identified (this led to some of the responses being excluded). Pilot feedback also revealed that some respondents were discouraged by the cumulative percentage questions. Unfortunately the survey was limited by the available software and it was, therefore, not possible to act upon these comments for the data collection. Access to such advanced software would reduce non-completion rate at data collection and the elimination of questionable responses at data cleansing. This would enhance the representativeness of the sample in relation to the general population of counselling psychologists across Europe and enable inferential statistical analysis of the data. Future research will also need to balance the deterring factor of too many questions with the deterring factor of fewer but more lengthy questions.

It may be interesting to repeat this survey in a few years to identify possible changes in the quantitative responses in relation to counselling psychologists' specific factors (e.g. training curriculum) and wider factors (e.g. employment opportunities or legislative and other social changes including social attitudes). Regarding the qualitative analysis, the authors recognise the benefits of using alternative qualitative methodologies (Oppenheim, 1992; Quinn Patton, 2002) that might illuminate further nuances in the topic. On the other hand, a particular strength of the methodological analysis (grounded theory informed approach) used in the current study is that the authors continually returned to the respondents' answers when analysing the data.

Years and areas of experience of European counselling psychologists

As acknowledge earlier, the overwhelming majority of the members of the European Association of Counselling Psychology have trained in the UK or work in the UK; yet also, a sizeable number of counselling psychologists working in Europe have trained in North America. As a result of researching this topic, additional observations can be made with regards the training and practical experience of counselling psychologists in Europe. Such surveys have been conducted, but not in recent times and generally within one country.

That a large proportion of the respondents reported that they had been working, at least on a part-time basis, in private practice could be linked to the fact that senior counselling psychologists have been "grandparented" in the profession; grandparenting refers to the happenstance where senior members have developed the competencies of a profession through diverse training paths prior to the introduction of accredited courses. This diversity seems to also be linked to

counselling psychology's community psychology traditions (Division of Counselling Psychology of the Hellenic Psychological Society, 2006; http://www.div17.org/preventionsection/default.htm), and these are reflected by the considerable number of respondents who reported to have worked for the charity and voluntary sectors (although this seems like a small adjunct to their main work portfolios). Many respondents also reported to have worked for the EAPs, and the increased profile of counselling psychologists in public mental health hospitals and clinics appears to be reflected in the finding that half of the respondents had experience in such settings. Forensic and social services employment were minimally represented in relation to the other work settings, but it is worth noting that the responses are relational to the extent of the respondents' professional experience, of which a large proportion had many years of experience; consequently, several respondents were considerably experienced in all listed work settings.

Main findings

The first notable finding from this survey is the small sample response to the invitation to participate. It might be speculated that failure to respond may be related to work- and personal-related competing priorities, i.e. non-respondents simply did not find the time to complete the survey. Evidence also suggests that the respondents' prioritisation of issues closely linked to disability influenced the response rate, meaning that those individuals in the sample population who completed the survey did so because they considered the research topic to be important whereas non-responders did not rate the topic so highly in importance. It might be inferred, therefore, that counselling psychologists do not consider disability to be as an important conceptual construct in their work as one might have assumed in light of the history of counselling psychology and its connections to aspects closely linked to disability. In light of the pervasive impact of disability discrimination legislation such as the Disability Discrimination Act (2006, 2008) on counselling psychology practice, this lack of prioritisation may be cause for concern and consequently the appropriate professional, training and regulatory bodies may need to take further action.

From the quantitative analysis, it is evident that the respondents in this survey were characterised by having many years of professional experience. This would support concerns that prequalification counselling psychology training does not sufficiently educate newly qualified counselling psychologists in the treatment of clients who have a disability; on the other hand, as counselling psychologists engage in their profession, the issue of disability is unavoidable and their learning increases in the context of ongoing professional development. However, coupled with the finding that counselling psychologists appear not to prioritise disability particularly highly in their work, this lends further weight to the argument for reviewing pre-

and even post- qualification counselling psychology training in the treatment of clients who have a disability.

Continuing in the same vein, even though almost all respondents reported that they had been providing a service to people with disabilities, across respondents the proportion of time spent providing a service to people with disabilities was comparatively small. Again, considering the large proportion of people who fall under disability discrimination legislation (e.g. over 10 million people in Britain; Office for Disability Issues, n.d.), this may be cause for concern and a rationale for investigating whether counselling psychology services are as accessible to people with disabilities as disability discrimination requires.

Despite the small sample size, however, the second most notable finding is the reinforcement of the characteristic of diversity, for which counselling psychologists as a professional group have a reputation. This is evident firstly, in the employment profiles of the respondents, secondly, in the types of disability-related services that the respondents reported they had been engaging, and finally, in their combined-model approach to therapeutic work with clients with disabilities.

Whilst diversity was shown in the types of disability-related services the respondents had been providing, this finding is qualified by the minimal amount of time they also reported that they had been dedicating to providing these services. One-to-one work with clients with disabilities was the only exception where the proportion of time spent providing this service varied greatly between respondents. This would suggest that counselling psychology skills are not widely utilised in a range of service provision. Pre-doctoral and post-doctoral internships could facilitate the broadening of such applications.

Diversity was also a theme within the work of the respondents. Only a very small minority of respondents reported they had been using just one model in their therapeutic work with clients with disabilities. The collective responses indicated that most practicing counselling psychologists use a combined approach in their disability-related work, which is in line with both the multi-model competencies of counselling psychologists in the UK and the scientist-practitioner paradigm (i.e. being open to all models that evidence indicates are potentially effective).

There were two areas in which the respondents showed less diversity than would be expected by the profession. One such area was that of research activity. The counselling psychology professional paradigm is traditionally that of a scientist/practitioner, however, the findings here suggest that counselling psychologists are attending much more to the practitioner aspect of their profession and to a much lesser extent the scientist aspect. This finding may have implications for the future of the profession: If the counselling psychology community continues to be relatively inactive in the area of research, then not only may the profession become stalled in its continuing development, but also the skill of practical research may become more and more diminished, thus damaging the quality of research that

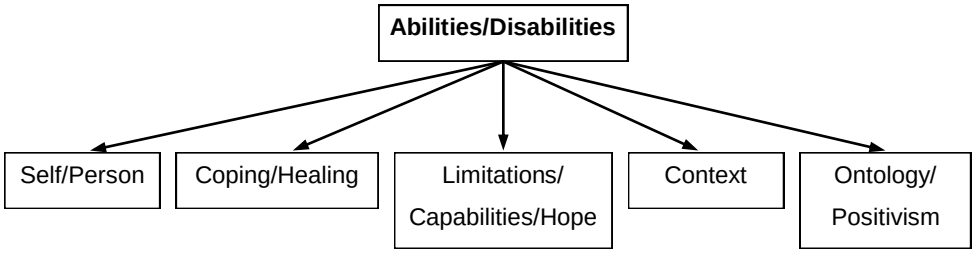

Figure 2 Conceptual tree developed by grounded theory analysis of the final question responses

is conducted. The authors consider this area as a very important focus for further counselling psychology research (e.g. what are the barriers and what support would counselling psychologists need to be more research active).

The other area of the survey that highlighted a lack of diversity was the reported use of communication aids other than art therapy. Guidelines for the use of interpreters in therapeutic practice have been published by the British Psychological Society (Tribe & Thompson, 2008). It is reported that there are about 60,000 deaf BSL users in the UK yet this form of communication is found here to be barely used in therapy. This brings into question yet again how adequately disability legislation is being adhered to by counselling psychology practitioners.

The final open question gave the respondents the opportunity to report their personal views without the restrictions of closed questions. Through grounded theory based qualitative analysis, the central notion that emerged in the final responses, and confirmed the validity of the data, was the concept of *Abilities/Disabilities*. It was anticipated that important dimensions within the conceptual construct of disability in relation to counselling psychology would include (a) the client and the deconstruction of boundaries between the client and therapist within disability and (b) the therapeutic relationship, the client, the therapist and the environment/context. The key thematic units that emerged in the answers, however, were *Self/Person*, *Coping/Healing*, *Limitations/Capabilities/ Hope*, *Context*, *Ontology/Positivism* (see Figure 2). That the tree, developed as an outcome of grounded theory-based analysis, appeared so different to the researchers' original conception gives support to grounded theory analysis as a useful methodology. The implications of this qualitative research are that these key areas may be used to guide future research as points to be addressed, as well as areas in planning training and reviewing counselling psychology practice.

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Appendix

The following are the quotations supporting the grounded theory based analysis. Numbers following each quotation identify the respondents. Those respondents whose qualitative answer passed data cleansing but were excluded in the quantitative analysis are identified by (X).

SELF/PERSON

...personal meaning of disability vs larger social/cultural environment, family environment/roles (25)

...sense of self other perceived in relation to self self experience in relation to other (26)

...self-self relationship... (54)

Client/Individual

The client as an individual (23)

... factors [intrapersonal,...] (9)

...ideal self... (5)

client's ... emotional well-being during sessions (28)

Person-Centred

The meaning the disability has for the client... (12)

"...his [or her] own personal growth?" (Rogers, 1961, p. 32, words in brackets added). (9)

Focus on clients' expressed concerns... (22)

I do not prioritise myself with client whether they have disabilities or not. (63)

To respect their needs, beliefs and desires NOT necessarily those of their family, carers and the "politically correct" (29)

Emotions

..they need to feel they can trust you... (7)

...social, emotional, psychologcial factors... (16)

...emotional adaptation to disability... (26)

...emotional well-being during sessions (28)

...dealing with their own feelings of anger, sadness, doubts at their ability to cope and shame. (35)

Proud of their disability (e.g. part of a community with hearing problems and their own language system) versus ashamed of their disability (e.g. a sufferer with Crohn's Disease) (23)

Also some parents find it hard to use local toddler or mum and baby groups because they are worried about other parents' reactions to their child and because of their own shame... (35)

Appearance

Feelings about part of their disability, (e.g. the distinctive facial features of Downs) (23)

Lost Abilities

I have found in my work the first major barrier to confront before work can began is the anger or frustration of the disabilities. (64)

Behavioural

what they would like to achieve unless there is a forensic or behavioural issue (57)

...behavioural and emotional adaptation to disability... (26)

Wish of the client

ideal self (5)

...expectation. (21)

...to respect their needs, beliefs and desires... (29)

Quality of Life

The client's needs and quality of life are the priority. (18)

Quality of life issues eg pain management, social support (45)

Goals

Hear his wishes and needs... (7)

Clear goal planning... (19)

...objectives and how if possible to achieve them... (73)

Motivating the client and others is what I see as an important goal. (19)

Requests/Demands

I ask them... (63)

Hear his wishes and needs... (7)

what they bring (57)

Needs

consider the needs of the individual... (15)

That the clients needs are understood... (37)

To respect their needs... (29)

Independence/ Functioning

...preparing the person for as much independence as possible... (46)

...to enhance their sense of self-esteem and personal autonomy... (11)

...most often the mother to interpret their world for them. (46)

...what would help him/her to be able to lead an independent life) (9)

Counselling Psychologist

That I explore and understand my own internal values and preceptions of issues around diability and consider how they may impact upon the therapeutic relationship. (37)

I myself am disabled (partially sighted). (42)

My interest in disability is entirely personal. (51)

...that I explore and understand my own internal values and preceptions... (37)

Awareness

awareness of the impact... (28)

...we need to be aware of the issues are not really what we are about. (19)

Impact

...of the impact of client's disability... (28)

Knowledge

awareness of the impact of client's disability on therapist and therapeutic relationship. (28)

Knowledge of particular health issues... (X)

Vigilance

Checks on effectiveness of therapy and providing feedback (13)

…check information is clear and conscise (34)

I also avoid the use of metaphor. (46)

Oppression

How ic onsider issues around powere and oppression and how they relate to the therapeutic setting/ context. (37)

Assumptions

To ascertain what the client is struggling with and to try to set aside my assumptions about this (49)

Movements

I am aware that it can be confusing for me to move around or wave my hands when talking and try to avoid doing this. (46)

Identity

the issues are not really what we are about. (19)

What identity the client has (23)

Acquired physical disability has thrown up issues around identity and loss... (35)

Ideology/Values

value base linked to social justice and social inclusion... (1)

Cognition

Clear goal planning... (19)

...their needs, beliefs and desires... (29)

How ic onsider issues... (37)

The client's perspective of their difficulties (23)

Phenomenology

Phenomenolgical (67)

Undertsanding of the cleint's here-and-now experience (67)

The client's view of their disability... (23)

...the respect for clients' phenomenological worlds that distinguishes counselling psychology from other disciplines... (9)

Sense-Experience

That I explore and understand my own internal values and perceptions... (37)

ease of access to appropriate services (58)

...pain issues... (17)

...how that impacts on them and their life (23)

anxieties (68)

bereavement and loss (68)

...the client feels heard, appreciated, understood... (32)

...what is troubling them. (32)

...interpret their world for them. (46)

...sense of personal power an individual experiences... (74)

...individual experience... (1)

Life

The client's view of their disability and how that impacts on them and their life (23)

...maintain life affirming changes. (75)

...quality of life are the priority (18)

...lives can be imporoved in the absence of cure. (19)

The issue is that living with a disability... (32)

Quality of life issues eg pain management, social support (45)

Difficulties

...are also going through some legal process for compensation and money becomes an issue for them. (32)

...empower them to ask their solicitors for what they -eg for an interim payment. (32)

Clients dont pay me they come via an agency who collects the money from the insurance company... (32)

...living with a disability does mean additional costs and often clients are disempowered by the doctors and solicitors to ask for financial support. (32)

Financial

...legal process for compensation and money becomes an issue for them. (32)

The issue is that living with a disability does mean additional costs and often clients are disempowered by the doctors and solicitors to

ask for financial support. (32)

Time

Past and Present

...the traumas of the past, so that they do not impinge on the client's present in such a negative way. (33)

Future

Good endings so that clients feels they have a resource if there is future need (13)

...so that any complications are avoided in the near future. (7)

COPING/HEALING

Containment of affect (14)

...doubts at their ability to cope and shame. (35)

Identifying and amplifying personal stengths, what has helped them cope in the past? (74)

I think that the way we are is as a result ans solutions we adopt in surviving our enviromnets and culture... (4)

...often mourning loss of wellness is a key theme... (39)

Acceptance

...accepting their child's disability... (35)

...self-compassion,... (74)

The ability to accept and transcend these problems (62)

...really listen to them and be patient. (31)

Acceptance of the client and their disability... (23)

Trying to be non judgmental (40)

Humanity

shared humanity (70)

real relationships (70)

Normalisation of the human experience (55)

To approach therapy from the standpoint of common humanity (29)

Adjustments

...cognitive/ behavioural and emotional adaptation to disability... (26)

Adjustment processes (60)

...offering home visits as an alternative approach to clients attending clinic. (76)

only experience of one client with signing interpretor (31)

That the clients needs are understood and adjustmens made to meet these to ensure equity of services. (37)

...adapt the session for that person to meet with their needs... (63)

A sense of the value in doing things a little differently, if that is what circumstances dictate. (53)

Loss

Good endings so that clients feels they have a resource if there is future need (13)

identity loss... (20)

...acquired a disability due to a traffic accident and thus have lost so much. (32)

...often mourning loss of wellness is a key theme... (39)

Acquired physical disability has thrown up issues around identity and loss... (35)

Change

...if we want to change society... (4)

Control

...managing risk... (16)

...have very little control over their own lives... (24)

LIMITATIONS/CAPABILITIES/HOPE

LIMITATIONS

Does it stop them from doing anything? (21)

Difficulty in them finding how to be assessed, treated, advised or helped. Lack of support through statutory agencies, schools, hospitals, GPs, etc. (2)

...if they are hard of hearing or have impaired sight... (56)

...Counselling Psychology will not get bogged down with the risk... (19)

Equal access as far as possible... (42)

If the client has the ability to attend the service they would not be discriminated

from attending the helath service. It does depend on their level sof severity and the resources we have. (56)

...in my work the first major barrier to confront... (64)

Sense of Uncertainty

...i hopefully empower my clients and don't disempower them as this only adds to the difficulties i feel. (63)

Risk

...Counselling Psychology will not get bogged down with the risk... (19)

managing risk... (16)

Client Risk (66)

I attempt to be sensitive particularly to areas of power - danger of looking down at or, worse, over the heads of wheelchair users. (44)

CAPABILITIES/HOPE

...helping people to find ways to be the most they can be, often in a social context. (59)

Strengths

self esteem (5 & 71)

confidence/competence (71)

...strengthen their existing abilities (11)

Finding strengths of client... (9)

...asset rather than deficit approaches. (1)

CONTEXT

...contextual thining wherein individual experience is located in wider personal, rlationship, organisational and ideological context... (1)

Breadth

...client's wider context… (54)

…individual experience is located in wider personal, relationship, organisational and ideological context... (1)

Social Context

...part of a community with hearing problems and their own language system... (23)

...personal meaning of disability vs larger social/cultural environment... (25)

...integrated social support. (75)

...environmental... (74)

...feminist and community psychological approaches... (1)

...social, emotional, psychologcial factors... (16)

Organisational Context

...personal, rlationship, organisational and ideological context... (1)

Stigma

...prejudice (20)

Also some parents find it hard to use local toddler or mum and baby groups because they are worried about other parents' reactions to their child... (35)

...psychological stigma... (60)

Systems

...systems thinking. (46)

...contributing factors [intrapersonal, interpersonal and systemic]). (9)

Inclusion/Exclusion

...that no-one is excluded through inaccessibily (15)

...social inclusion... (1)

Access

ease of access to appropriate services (58)

...transport... (15)

...struggles to access sufficient or appropriate help. (35)

I am conscious of the need for disability access. (44)

Physical acces to premises. (40)

Dynamics

...family environment/roles (25)

...changes in relationships and roles within the family. (35)

Power dynamics (67)

Relational

...relational focus. (74)

Without alliances... (75)

...how they relate to the therapeutic setting/context. (37)

Relational Complexity

...interconnected web of complex relationships. (75)

It does depend on their level sof severity... (56)

Intrapersonal Relationships

...self-self relationship,... (54)

...few relationships that do not place him/her at a disadvantage... (75)

...how they relate to the therapeutic setting/context. (37)

Without alliances... (75)

...relational focus. (74)

Parents/Young Children

For parents with young children who have learning disabilities... (35)

...tend to rely on a parent, most often the mother... (46)

Protectiveness

...as well as protectiveness. (35)

Couples

Intimacy and sexuality... (38)

Offering couples therapy... (76)

Peers

peer relations (5)

Family

family relations (5)

...family networks... (19)

Carers

...carers... (29)

Attachment

attachment (20)

Authenticity

real relationships (70)

Statutory Agencies

...through statutory agencies, schools... (2)

Social Action

...how service provisions can assist and facilitate... (X)

That the clients needs are understood and adjustmens made to meet these to ensure equity of services. (37)

Legal

...through some legal process for compensation and money... (32)

Intrapersonal Care

...children being taken into Care. (35)

Political

...the "politically correct" (29)

...i have become more political... (4)

Helping

Working towards resolving or reducing those concerns... (36)

I have found in my work the first major barrier to confront before work can began... (64)

...positive affirmations that lives can be imporoved in the absence of cure. (19)

To give my clients a space where they can "work through" the traumas of the past so that they do not impinge on the client's present in such a negative way. (33)

Therapeutic Relationship

Naming what is in the room (69)

...offering a trusting relationship (74)

...provide a secure base, a vehicle for change. (73)

Strong therapeutic alliance (13)

...relational depth (17)

Establishment of a safe therapeutic relationship (29)

Working together on issues... (X)

That I explore and understand my own internal values and preceptions of issues around diability and consider how they may impact upon the therapeutic relationship. (37)

A joy in the therapeutic relationship (53)

I try to act as a back up and to give the an experience of talking with someone else. (46)

When working with learning disabled people, I aim for warmth and clarity and full respect of their emotional intelligence. (44)

...I also place the therapeutic relationship at the centre of the therapeutic endeavour. (9)

I always try to engage the client and build a relationship based on trust, and genuineness. (7)

Communication

...good communication (X)

between client and the supportive family networks about plans and support necessary... (19)

Making sure the client feels heard... (32)

When working with learning disabled people, I aim for warmth and clarity... (44)

…if they are hard of hearing or have impaired sight then they will be seen as any other client referred to the service. (56)

only experience of one client with signing interpretor (31)

…providing feedback (13)

The importance of taking time to learn the clients' own personal language (29)

Their relief in finding someone who can explain properly,... (2)

The issue of confidentiality I always explain in the first session my confidentiality policy... (7)

Information

Witness to their Narrative Containment of affect (14)

Discovering all relevent information. (27)

...check information is clear and conscise (34)

Expression

Focus on clients' expressed concerns and be sensitive to those possibly not being expressed (22)

Clarity

communication and clarity (48)

Communication Restraint

...can be confusing for me to move around or wave my hands when talking and try to avoid doing this. (46)

Sharing

Sharing the experience with the client (27)

Appreciation

...to value them as an individual. (46)

Respect

To respect their needs, beliefs and desires... (29)

...respect for the individual's own strategies... (10)

...respect for them as person... (39)

...the respect for clients' phenomenological worlds that distinguishes counselling psychology from other disciplines... (9)

Priorities of the client

With the client prioritising those concerns... (36)

...do not prioritise myself... (63)

Sameness/Difference

Meaning of the therapist not having the same physical illness... (X)

...sameness vs difference (38)

I do not work any differently with people with disabilities... (63)

...while respecting the essential difference between our experience of life. (44)

...the distinctive facial features of Downs (23)

Acceptance of the client and their disability (what's yours

called?- mine is myopia and the inability to do reversal operations cognitive) (23)

Normalisation

Normalisation of the human experience (55)

Normalising (69)

Focus on treating individuals in non-stigmatising and non-pathologising ways (74)

Alternative-Adjustments

Adjustment processes... (60)

…adapt the session for that person… (63)

Care

Working with adults with learning disability (only mild to moderate for my work) the issues are varied, but have included relationship problems and coping with children being taken into Care. (35)

Ethics

...consideration of moral and ethical issues when working with adults with a learning disability... (75)

Responsibility

power and responsibility (48)

Competence

...I have adequate training to work within my level of competence. (37)

Training

...I have adequate training to work... (37)

Empowerment

...positive affirmations that lives can be improved in the absence of cure. (19)

Empowering the client disability or not (23)

...often clients are disempowered by the doctors and solicitors to ask for financial support. (32)

Power dynamics (67)

...as a rule people with learning disabilities can be disempowered... (75)

empowerment self as own expert (47)

Power-mapping...eliciting a shared understanding of the sense of personal power an individual experiences, and the factors contributing to this. (74)

Identifying and amplifying personal stengths... (74)

...to enhance their sense of self-esteem and personal autonomy and strengthen their existing abilities. (11)

Collaboration

A really good formulation done in conjunction with the client. Not adopting too much of an "expert" role. (27)

Trust/Safety

Establishment of a safe therapeutic relationship (29)

therapeutic relationship, especially issues of trust... (25)

...they need to feel they can trust you in order for them to open up (7)

Ending

Good endings... (13)

Assessment/Treatment

Difficulty in them finding how to be assessed, treated, advised or helped. (2)

Model

Working alongside the medical model... (X)

Implicitly, we also tend to adhere to the social model of disability... (21)

...action reseqrch approaches, feminist and community psychological approaches, asset rather than deficit approaches. (1)

...asset rather than deficit approaches. (1)

Efficacy

Checks on effectiveness of therapy... (13)

Creativity

...try to work flexibly and creatively... (15)

Practice-based Literature

...Forster P. and Tribe R. (2005) 'Professional and ethical issues when working with learning disabled clients' in Tribe R. and Morrissey J. Handbook of Professional and Ethical Practice for Psychologists, Counsellors and Psychotherapists.(2005). Brunner-Routledge. (75)

Cure

...affirmations that lives can be imporoved in the absence of cure. (19)

Motivation

Motivating the client and others. (19)

Teach/Learn

Positive thinking (6)

The importance of taking time to learn the clients' own personal language (29)

a desire to learn about his/her world... (65)

Teaching skills client can use on own... (X)

...teach them empathy for others. (4)

Educate immediate environment... (6)

Assist/Facilitate/Enable/Support

...helping people to find ways to be the most they can be... (59)

...struggles to access sufficient or appropriate help. (35)

…providing feedback (13)

...how servcie provsions can asssist and facilaiate client's development (16)

…creatively to enable positive engagement in assessment/therapy. (15)

I try to act as a back up... (46)

…to enhance their sense of self-esteem... (11)

We also always establish the clients support levels. (21)

Resources

…they have a resource if there is future need (13)

Working towards resolving or reducing those concerns (which could involve external resources) (4)

…the resources we have. (56)

…what has helped them cope in the past? (74)

Dependence

...the mother to interpret their world for them. (46)

Equality/Non-Discrimination

...the client disability or not (23)

equal opportunities (41)

ensure equality in service... (15)

That the client recieves equitable services. (37)

Social Justice

value base linked to social justice... (1)

...through some legal process for compensation and money... (32)

Financial Context

...to ask their solicitors for what they –eg for an interim payment. (32)

...a disability does mean additional costs... (32)

...clients are disempowered by the doctors and solicitors to ask for financial support. (32)

Clients don't pay me they come via an agency. (32)

ONTOLOGY/POSITIVISM

Part-Whole

…part of a community with hearing problems... (23)

...to understand more fuller how the persons' disfigurement is affecting their lives. (21)

Feelings about part of their disability... (23)

The client as a whole (disability as part of that whole but not the complete person) (23)

I attempt to as fully as possible enter their experience... (44)

...often have very little control over their own lives... (24)

Also some parents find it hard to... (35)

...their existing abilities (11)

All persons can move ahead in some unqiue way or other... (8)

Their relief in finding someone who can explain properly... (2)

Most of my clients... (32)

Knowledge of particular health issues... (X)

A sense of them as an individual, not as a range of symptoms. (53)

Within our area in particular this may require us to understand more fuller... (21)

...important to remember that people do not exist in isolation, but rather embedded within an interconnected web of complex relationships. (75)

...that no-one is excluded... (15)

specific understanding of the disability... (28)

Degree

It does depend on their level sof severity... (56)

Good/Bad

Good endings... (13)

Understanding

The meaning the disability has for the client... (12)

…our exploration with clients and others. (21)

Understanding the clients perspective. (27)

care to be fully understood (65)

...eliciting a shared understanding of the sense of personal power an individual experiences... (74)

...then I make sure the caretakers understand it... (7)

Reasons

I also try to formulate the reasons that have contributed to the developemnt of my client's current difficulties... (9)

Core

Core pain issues relational depth (17)

Valuing

...to value them as an individual. (46)

Physical/Emotional

…physical disabilities... (24)

Physical access... (X)

...hospitals, GPs... (2)

client's physical and emotional well-being... (28)

Actions

...what does the client wish to change. (21)

Does it stop them from doing anything? (21)

...how others respond to their disability (39)

...maintain life affirming changes. (75)

...action reseqrch approaches... (1)

…address practical issues... (15)

Health/Illness

…factors whihc contribute to illness… (16)

Knowledge of particular health issues… (X)

…acquired brain injury… (24)

...emotional well-being… (28)