

Psychotherapy Experiences of U.S. Adults With Physical Disabilities: Recommendations for Affirmative Practice^Ψ

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Abstract

Mental health providers often have little to no training on working with disabled people, and may hold negative biases toward disability (American Psychological Association [APA], 2022). Given these conditions, this study fills a gap in knowledge about the experiences of people with physical disabilities in psychotherapy, and data-driven disability-affirmative approaches. Purposive sampling was used to recruit people with physical disabilities ($N = 24$) through social media, who participated in semi-structured individual interviews about their psychotherapy experiences. Consensual qualitative research methods revealed four overarching domains with multiple underlying themes. The four

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This study is dedicated to the memory of R. E. Franco Durán, Ph.D.

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domains were: (a) positive therapeutic interventions and interactions, (b) negative therapeutic interventions and interactions, (c) in/accessibility of services, and (d) suggestions for improving mental health services. The results inform affirmative practices for psychotherapy with a stigmatized population. Implications for culturally-responsive clinical practice and training are discussed, as well as study limitations and directions for future research.

Keywords

disability, psychotherapy, cultural competence, affirmative, qualitative

Significance of the Scholarship to the Public

This study's findings identify affirming and harmful psychotherapy practices with physically disabled clients. The results allow the perspectives of disabled mental health consumers to inform disability-affirmative psychotherapy guidelines and clinical training.

Introduction

Approximately one-fourth of noninstitutionalized adults in the United States report having a disability (i.e., impairment related to mobility, vision, hearing, cognition, or independent functioning; Okoro et al., 2018). Of these disabilities, about half are mobility impairments and another 10% are sensory impairments (Okoro et al., 2018). One of the largest oppressed groups in the United States (Nario-Redmond, 2020), people with disabilities¹ experience significant mental health disparities compared to nondisabled people (Cree et al., 2020; Meltzer et al., 2012; Turner et al., 2006). People with physical disabilities, in particular, demonstrate higher rates of mental health and substance use disorders (Cree et al., 2020). Moreover, disabled people are more likely than nondisabled people to receive mental health treatment (National Center for Health Statistics, 2021). According to a 2020 survey by the Centers for Disease Control and Prevention, 17.5% of disabled people received mental health counseling in the past 12 months, compared to 9.3% of people without disabilities (National Center for Health Statistics, 2021). Additionally, 27.5% of disabled people took prescription medication for anxiety and 25.5% for depression, compared to 10.6% and 8.8% of people without disabilities, respectively (National Center for Health Statistics, 2021).

It can be difficult to draw boundaries around the socially-constructed category of disability (Nario-Redmond, 2020), and subcategory of physical disability. For the purpose of this study, physical disabilities refer to mobility or sensory impairments, chronic illnesses, and medical conditions, or being perceived as having such impairments or conditions. Well-known examples

include amputation, blindness and low vision, cerebral palsy, rheumatoid arthritis, and spinal cord injury. Throughout this article, “disability” will be used when referring to people who identify with any type of disability (e.g., developmental, psychiatric, physical), whereas “physical disability” is specific to this subsection of the disability community.

Ableism and Mental Health Services

Higher rates of negative mental health outcomes among disabled people have been associated with ableism (Conover & Israel, 2019; Green, 2003; Mazur, 2008; Turner & Turner, 2004). Ableism can be defined as “a network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as the perfect, species-typical and therefore essential and fully human” (Campbell, 2001, p. 44). Through the lens of minority stress theory (Meyer, 2003), psychologists can understand how ableism affects individual distress and dysfunction among people with disabilities. Understanding minority stress, however, does not preclude the field of psychology from reproducing ableist ideology.

Ableism shapes all systems and institutions. Thus, mental healthcare settings have the potential to exacerbate disabled peoples’ psychological distress and dysfunction. In fact, there is evidence to suggest that some mental health providers (MHPs) hold biases or negative views about disability (American Psychological Association [APA] 2022; Hunt et al., 2006). MHPs with prejudiced attitudes about disability can harm disabled clients, such as through inaccessibility of services and verbal ableist microaggressions. Ableist microaggressions are negative slights about disability status (Keller & Galgay, 2010), and have been connected to increased depression among disabled people (Conover & Israel, 2019). When underserved groups access mental health services, they are at risk of experiencing microaggressions by MHPs (Mazzula & Nadal, 2015), including clients with physical disabilities (Hunt et al., 2006). The potential harm of ableist microaggressions in psychotherapy is also reflected in the APA’s (2017) *Multicultural Guidelines*, which highlight damaging effects to the working alliance (p. 32). Without proper clinical training guided by disability communities, MHPs will be less likely to provide the safety and validation necessary for a strong alliance and positive therapy outcomes (Levitt & Williams, 2010).

Cultural Competencies With Disabled Clients

Despite high rates of adverse mental health outcomes and utilization of mental health services, along with the potential for ableist microaggressions to occur in therapy, MHPs typically receive little to no training in working with disabled people (APA, 2022; Artman & Daniels, 2010). Although accredited

clinical graduate programs in the United States include coursework on diversity and culture, there is an appalling lack of attention given to disabled clients (APA, 2022; Artman & Daniels, 2010). One reason for the lack of training is a significantly limited body of research on culturally-responsive treatment with disabled people. Despite counseling psychology's commitment to diversity and multiculturalism, an analysis of articles published in five major counseling psychology journals between 1990 and 2010 found that only 1% focused on disability (Foley-Nicpon & Lee, 2012). In another systematic review of empirical articles in medical and psychology literature from 1990 to 2015 aimed at improving disability cultural competence, Butler et al. (2016) found only two studies using samples of MHPs. As noted by Artman and Daniels (2010), "there are no evidence-based practices (EBPs) for clients with disabilities," due to the dearth of psychological research on disability (p. 443).

In conceptual academic literature across fields, scholars have written about disability and ableism for decades (Nario-Redmond, 2020). In the specialization of rehabilitation psychology, core competencies and training principles have been outlined for working with disabled clients (Stiers, 2016; Stiers et al., 2015; Wright, 1983). In applied psychology broadly, Olkin (2007, 2017) described key considerations and cultural competencies in her work on disability-affirmative therapy (D-AT). D-AT is a treatment approach that includes an affirming and constructivist therapist stance toward disability and active exploration of the client's life and context, including ableist micro-aggressions, intersecting diversity variables, and engagement with disability culture and communities (Olkin, 2017). Other applied psychology scholars have also expanded on important awareness, knowledge, and skills with disability populations (Andrews, 2020; Foley-Nicpon & Lee, 2012). APA (2022) recently published revised *Guidelines for Assessment and Intervention With Persons with Disabilities*, which provides 23 guidelines regarding psychologists' disability knowledge and awareness, training and education, accessibility of services, disability-affirming language and behavior, within-group diversity, and psychological intervention and testing. Despite this work, the authors know of no empirical evidence suggesting that disabled clients typically receive affirming and culturally-responsive mental health services.

Aims of the Present Study

Previous research has explored helpful and unhelpful therapist approaches and behaviors with other diverse groups (e.g., Israel et al., 2008; Schechinger et al., 2018). Currently, however, there is a gap in such research with disability populations. A small number of studies have explored the psychotherapy experiences of people with other types of disabilities (e.g., learning disabilities; Lewis et al., 2016) and specific subpopulations (e.g., lesbians with physical disabilities; Hunt et al., 2006). Other recent studies have also started

to broaden this literature (Gomez & Olkin, 2022). To contribute to this important research, the purpose of this study was to expand understanding of affirming psychotherapy approaches and techniques for clients with physical disabilities.

To the authors' knowledge, the current study is the first to broadly explore people with physical disabilities' experiences in psychotherapy and suggestions for improving mental health services using qualitative methods. Meeting calls for such research (Olkin, 2017), the present study centers disabled perspectives to empirically determine how MHPs can engage in affirmative psychotherapy with this population. The research aims are to identify affirming and harmful practices of MHPs when working with clients with physical disabilities, and to integrate the perspectives of disabled mental health consumers into D-AT approaches. The results have implications for data-driven guidelines for disability-affirming clinical practice. This research is guided by the following overarching questions: (a) What are people with physical disabilities' positive and negative experiences in psychotherapy? and (b) What do people with physical disabilities believe MHPs should know, believe, say, or do to hold and convey an affirmative stance when treating clients with physical disabilities?

Methods

Participants

Twenty-four people participated in the study. In order to be eligible for the study, participants were required to have engaged in psychotherapy with a licensed MHP in the United States for at least one session in the past 10 years. No one who requested to participate was deemed ineligible. Participants were recruited nationally through disability-related social media groups in fall 2019, prior to the onset of the COVID-19 pandemic in the United States. Facebook was the primary social media outlet for recruitment. Purposive sampling was used to target people who self-identified as having a physical disability, and recruitment strategies aimed to increase sample diversity. The researchers posted to general groups for disabled people, as well as groups for multiply-marginalized disabled people, such as for gay disabled people, disabled people of color, and groups for people with specific disabilities (e.g., spinal cord injuries, Ehlers-Danlos Syndrome, and Charcot-Marie-Tooth disease). Flyers and announcements specifically calling for men and men of color were repeatedly posted on social media, specifically on Facebook groups for disabled men and men in general. Men were also targeted through snowball sampling. Although men were ardently targeted for recruitment in these ways, no men participated in the study.

The final sample included 21 women and 3 nonbinary people. Participants ranged in age from 20 to 51 years, with an average age of 32. Approximately one-third of participants were people of color and two-thirds were LGBTQ+. Most participants reported having multiple types of physical disabilities (e.g., a mobility impairment and a chronic illness/medical condition), and the vast majority had a semi-visible or invisible disability. Nineteen participants provided further details about their specific disabilities, including diagnoses such as arthrogryposis, Charcot-Marie-Tooth disease, Ehlers-Danlos syndrome, fibromyalgia, stroke and post-stroke fatigue syndrome, postural orthostatic tachycardia syndrome, psoriatic arthritis, Raynaud's disease, and rheumatoid arthritis. The mean length of participation in therapy was about 6 years, and altogether participants brought over 150 years of experience as psychotherapy clients. See [Table 1](#) for general participant demographics, [Table 2](#) for participants' disability-specific characteristics, and [Table 3](#) for participants' psychotherapy experiences.

Procedure

The study was approved by a university institutional review board. Individuals interested in participating contacted the first author and were screened via phone. Prior to the interview, participants completed the informed consent and demographics questionnaire via Qualtrics and were provided a list of mental health resources and disability rights organizations. Semi-structured individual interviews were conducted by the first and second authors. Interviews primarily took place via Skype, but a few were conducted in-person in a private office due to participant preference. Interviews lasted 30–90 minutes and were audio-recorded via QuickTime Player. Participant demographics and basic interview themes were monitored and discussed by the interviewers to determine when theoretical saturation was reached and subsequently, to stop recruiting participants. Participants were provided a \$30 gift card as an incentive. Interviews were transcribed using NVivo Transcription software. The transcriptions were audited to correct errors and redact identifying information. The clean transcripts were uploaded to Dedoose, a qualitative data analysis software, for use by the research team.

To increase mutuality in the flow of information (i.e., participant to researcher and researcher to participant), all participants were emailed a summary of the study findings, a description of how they were disseminated (i.e., several graduate courses and a conference presentation), and the plan for next steps. Participants were invited to respond with comments and three responses were provided: one participant asked to give the summary to their MHP to distribute, one described improved access to online psychotherapy due to the COVID-19 pandemic, and one asked for a copy of the published article.

Table 1. Demographic Characteristics of Participants

Variable	Range	Mean
Age	20–51	31.88
Income	\$0–\$144,000	\$24,946
Variable	Response options	<i>n</i> (%)
Gender	Women	21 (87.5%)
	Nonbinary	3 (12.5%)
Race and Ethnicity ^a	White or European American	16 (66.7%)
	Latinx, Hispanic, or Chicana	2 (8.3%)
	Asian or Asian American	1 (4.1%)
	Multiracial	4 (16.7%)
Education	High school diploma or GED	2 (8.3%)
	Some college	6 (25.0%)
	Associate's degree	2 (8.3%)
	Bachelor's degree	4 (16.7%)
	Some graduate/professional school	4 (16.7%)
Employment Status	Graduate or professional degree	6 (25.0%)
	Regular full-time employment	5 (20.8%)
	Regular part-time employment	4 (16.7%)
	Contingent/on-call employment	1 (4.1%)
	Student	7 (29.2%)
	Unemployed w/ disability or benefits	4 (16.7%)
Socioeconomic ^a	Unemployed	3 (12.5%)
	Poor	5 (20.8%)
	Lower-middle class	3 (12.5%)
	Working class	5 (20.8%)
	Middle class	4 (16.7%)
Living Environment	Upper-middle class	5 (20.8%)
	Rural	1 (4.1%)
	Suburban	4 (16.7%)
	Small city or town	10 (41.7%)
	Medium-sized city	3 (12.5%)
	Urban or large city	6 (25.0%)
Religion	Christian	7 (29.2%)
	Jewish	3 (12.5%)
	Spiritual Religion	4 (16.7%)
	Multiple	3 (12.5%)
	None	7 (29.2%)

(continued)

Table 1. (continued)

Variable	Response options	<i>n</i> (%)
Sexual Orientation	Heterosexual or straight	8 (33.3%)
	Bisexual or pansexual	8 (33.3%)
	Lesbian	1 (4.1%)
	Gay	1 (4.1%)
	Asexual or demisexual	5 (20.8%)
	Questioning	1 (4.1%)
Relationship Status	Single	7 (29.2%)
	Dating or partnered	7 (29.2%)
	Married, domestic partnership, civil union	10 (41.7%)

Note. *N* = 24. Participants selected from response options provided or wrote in their own response.

^aMissing data.

Table 2. Disability Characteristics of Participants

Variable	Response options	<i>n</i> (%)
Disability Type	Chronic illness/medical condition	6 (25%)
	Mobility impairment	3 (12.5%)
	Sensory impairment	0 (0.0%)
	Brain injury	0 (0.0%)
	Multiple disabilities	15 (62.5%)
Physical Disability	Acquired	9 (37.5%)
	Congenital	4 (16.7%)
	Both	11 (45.8%)
Disability Visibility	Visible disability	2 (8.3%)
	Semi-visible disability	13 (54.2%)
	Invisible disability	9 (37.5%)
Disability Severity	Mild	1 (4.1%)
	Moderate	16 (66.6%)
	Severe	7 (29.2%)
	Very severe	0 (0.0%)
Disability Identity	Do not identify	2 (8.3%)
	Somewhat do not identify	1 (4.1%)
	Neutral	0 (0.0%)
	Somewhat identify	13 (54.1%)
	Strongly identify	8 (33.3%)

Note. *N* = 24. Participants selected from response options provided.

Table 3. Psychotherapy Experiences of Participants

Variable	Range	Mean	Median
Time in Therapy	2 mo.–25 yrs.	6.4 yrs	4.2 yrs
Variable	Response options	n (%)	
Psychotherapy Type ^a	Individual	24 (100%)	
	Group	12 (50.0%)	
	Couples	8 (33.3%)	
	Family	5 (20.8%)	
Psychotherapy Setting ^a	Private practice	23 (95.8%)	
	University counseling center	9 (37.5%)	
	Community agency	4 (16.7%)	
	Inpatient hospitalization	3 (12.5%)	
	Partial hospitalization	1 (4.1%)	
	Disability-related or medical agency	2 (8.3%)	
	Religious agency	3 (12.5%)	
	K–12 school	1 (4.1%)	
	Don't know or unsure	13 (54.2%)	
Psychotherapy Approach ^a	CBT	11 (45.8%)	
	EMDR	4 (16.7%)	
	Psychodynamic or psychoanalytic	2 (8.3%)	
	ACT	1 (4.1%)	
	DBT	2 (8.3%)	
	Systemic family therapy	3 (12.5%)	
	Behavior modification	1 (4.1%)	
	Developmental	1 (4.1%)	
	Don't know or unsure	13 (54.2%)	
MHP Training ^a	Doctoral-level	14 (58.3%)	
	Masters-level	18 (75.0%)	
	Don't know or unsure	3 (12.5%)	

(continued)

Table 3. (continued)

Variable	Response options	n (%)
Reasons for Seeking Psychotherapy ^a	Disability-related	16 (66.7%)
	Other medical issues	11 (45.8%)
	Career/employment/ school	13 (54.2%)
	Depression	20 (83.3%)
	Anxiety	19 (79.2%)
	Stress	16 (66.7%)
	Trauma	14 (58.3%)
	Adjustment	5 (20.8%)
	Family relationships	16 (66.7%)
	Substance use	2 (8.3%)
	Eating concerns	3 (12.5%)
	Gender or sexuality	2 (8.3%)
	Other mental health issue	7 (29.2%)
Was disability a focus of treatment?	Yes	17 (70.8%)
	No	7 (29.2%)
How much disability-related training do you think your MHP had?	A lot	1 (4.1%)
	Some	7 (29.2%)
	Very little	12 (50%)
	None	0 (0.0%)
	I don't know	4 (16.7%)
Overall Experience in Psychotherapy/ Counseling	Extremely positive	1 (4.1%)
	Very positive	9 (37.5%)
	Somewhat positive	10 (41.7%)
	Neutral	0 (0.0%)
	Somewhat negative	0 (0.0%)
	Very negative	0 (0.0%)
	Extremely negative	0 (0.0%)
	Mixed feelings	4 (16.7%)

Note. *N* = 24. Participants selected from response options provided. Some response options that were not endorsed by any participants were omitted from this table. CBT = cognitive behavioral therapy, EMDR = eye movement desensitization and reprocessing, ACT = acceptance and commitment therapy, DBT = dialectic behavior therapy, MHP = mental health practitioners.

^aDue to the ability to select more than one response option, percentages total greater than 100%.

Measures

Demographic Questionnaire. Participants completed a demographic questionnaire including age, disability, education, employment, gender identity, geographic region, race and ethnicity, sex, sexual orientation, and socioeconomic status. Responses on the demographic questionnaire were used to describe the sample and position findings in the literature.

Semi-Structured Interview. Participants were asked open-ended questions about their experiences in psychotherapy, including, “Tell me about times you had positive experiences in therapy related to having a disability,” “Tell me about times you had negative experiences in therapy related to having a disability,” “What topics have you discussed in therapy that you felt were particularly helpful as a person with disabilities?,” “Were there other aspects of your identities or group memberships (such as your gender, race or ethnicity, sexual orientation, or religion) that affected your experiences in therapy?,” “How was the physical setting of the therapist’s building or office for you as a person with disabilities?,” and “What do you wish all therapists would know before working with people with disabilities?” In the case of short or unclear responses, the interviewer asked unplanned follow-up questions.

Researcher Subjectivity and Reflexivity

The research team was made up of one faculty member and four clinical psychology doctoral student research assistants. The first author was a White, queer woman in her 30s with childhood-onset invisible physical disabilities, who was a faculty member and practicing licensed psychologist. Data analysis was conducted by the research assistants; the auditor was a nondisabled Mexican and Cuban American heterosexual woman in her 20s, and the coders were an Iranian American heterosexual woman in her forties who has a visible physical disability with onset in young adulthood and uses a wheelchair, a nondisabled heterosexual White woman in her 30s, and a nondisabled Mexican American heterosexual woman in her 20s. All research team members were cisgender. The last author was not a member of the original research team, but assisted with reporting and dissemination of the findings. She is a White, queer cisgender woman in her thirties without physical disabilities; she is the spouse of the first author; and she is a practicing licensed psychologist, a researcher with qualitative experience, and a mental health content writer.

The authors came to the project with varying degrees of experience and familiarity with disability issues and scholarship. All authors, however, hold a disability-affirmative stance and understand disability and mental health through minority stress and social justice lenses. We also believe that: (a) disability is socially constructed and ableism permeates all aspects of society, including psychotherapy, and (b) currently, applied psychology largely fails disabled people due to widespread discomfort with disability, lack of education and knowledge about disability issues, lack of self-awareness among nondisabled people in power (e.g., MHPs, researchers, faculty), and a dearth of research and training on D-AT and related skills.

Interviews for the current study were primarily conducted by the faculty researcher, who expected participants would share experiences reflecting a

lack of disability competence among MHPs. To bracket her emotional reactions and assumptions, the interviewer processed some interview experiences with the last author. The doctoral student auditor also conducted a small number of the interviews, and the two interviewers processed their experiences and emotional reactions together.

Through the data analysis process, the research assistants maintained awareness of their cultural backgrounds, disability status, and experiences and beliefs, through regular open dialogues. Their differing cultural backgrounds allowed for diverse perspectives, and these conversations helped to increase self-knowledge and reduce assumptions and biases about disability. This allowed for bracketing of assumptions and emotional reactions during data analysis and contributed to the trustworthiness of the data (see [Morrow, 2005](#)).

Data Analysis

Transcripts were coded via consensual qualitative research (CQR; [Hill, 2012](#)). CQR has constructivist and postpositivist elements to its philosophy, acknowledging the influence of the researchers while striving for objectivity ([Hill et al., 2005](#)). [Hill et al. \(2005\)](#) noted that CQR is particularly useful for studying phenomena which have not been previously researched. CQR allowed the research team to identify themes that inform affirmative psychotherapy practices with disabled people. The research team was trained in CQR primarily by the auditor, who brought recent CQR experience and provided the team with didactics and readings.

Per the CQR protocol outlined by [Hill \(2012\)](#), “domains” were first created by each research team member based on the existing literature relevant to the interview questions, and then expanded to include all the data found within the transcripts. Next, “core ideas” were created within each domain that summarized participant statements. Research team members discussed until consensus was reached regarding each domain and core idea. Upon compiling all domains and core ideas, “categories” or themes were created that incorporated all core ideas within each domain based on consensus. If consensus could not be reached at any point during the coding process, the auditor made the final determination. Throughout analysis, the faculty researcher debriefed team members individually to ensure they participated and felt heard in the consensus process.

Results

Participants described multiple themes within four overarching domains. The domains included: (a) positive therapeutic interventions and interactions, (b) negative therapeutic interventions and interactions, (c) in/accessibility of services, and (d) suggestions for improving mental health services. Within

the domains, themes were categorized as “general” (23–24 cases), “typical” (12–22 cases), or “variant” (4–11 cases). Within the four domains, no themes had fewer than four cases. The domains and themes are presented in Table 4. Participants are identified using researcher-selected pseudonyms, which are all common names based on the participant’s gender and race/ethnicity during the year they were born.

Domain 1: Positive Therapeutic Interventions and Interactions

This domain refers to positive counseling or psychotherapy experiences, or instances when an MHP employed helpful or affirming techniques. Themes include progress and personal growth through psychotherapy, MHP responsiveness to disability-related concerns, nonspecific positive psychotherapy experiences, and attending to physical and psychological symptoms.

Progress and Personal Growth Through Psychotherapy. Almost all participants reported that psychotherapy helped them to grow personally, and to develop a new perspective on life and their disabilities. These participants focused on how psychotherapy helped them to increase acceptance of their disability, manage and address negative judgements by others, develop strength and self-confidence, or be kinder to themselves. Rachel (White, asexual woman in her 30s, with a mobility impairment and chronic illness) stated, “It was a huge thing for me to start debating with myself. ‘Was I disabled?’... I wrestled with it for a long time... Coming to terms with the fact that I was disabled was a long and challenging process.” Another participant, Irene (Latinx, heterosexual woman in her 40s, with a mobility impairment and chronic illness) reported:

I found it helpful for someone outside of myself to give me permission, or not even just permission—as a mandate to say, “No, you have to accept this. You have to acknowledge that this is a big deal. It does suck to be sick all the time.” Or, “It does suck to not be able to sleep.” So, it was good to have somebody outside of myself—not just to say, “Oh, that’s got to be terrible,” or “Oh, that must be really difficult,” but to say, “Yes, it’s difficult. It’s okay to accept that it’s difficult. It’s okay to say it sucks. It’s okay to say, why me?”

Responsive to Disability-Related Concerns. More than three-fourths of participants described positive experiences in psychotherapy regarding discussion of their disabilities and other disability-related issues. MHP responsiveness to disability-related concerns, which participants described as understanding and acceptance of their disabilities, included processing disability experiences with their MHPs, receiving support during physical health crises, and developing a positive disability identity. For example, Mercedes (American

Table 4. Frequency of Themes by Domain

Domain	Themes	Frequency (n)
Positive Therapeutic Interventions and Interactions		
Helpful, appropriate, or positive instances in psychotherapy or provider techniques	Progress and personal growth through psychotherapy	Typical (20)
	Responsive to disability-related concerns	Typical (19)
	General positive therapy experiences	Typical (18)
	Managing physical and psychological symptoms	Typical (13)
	Self-disclosure of disabilities	Variant (11)
Negative Therapeutic Interventions and Interactions		
Unhelpful, inappropriate, or negative instances in psychotherapy or provider techniques.	Avoiding disability topics	Typical (19)
	Invalidating disability experiences	Typical (14)
	Responding inflexibly or inappropriately	Typical (14)
	General negative experiences	Variant (10)
	Attributing physical disability to psychopathology	Variant (8)
	Worsening physical or psychological symptoms	Variant (8)
In/Accessibility of Services		
The extent to which people are able to access psychotherapy services	Inaccessibility of psychotherapy services	General (23)
	Inadequate insurance coverage or high costs	Typical (17)
	Poor physical setting of the provider's office	Typical (16)
	Barriers to finding or scheduling therapy	Typical (15)
	Barriers to transportation or parking	Typical (14)
	Accessibility of psychotherapy services	Typical (21)
	Willing or attempting to accommodate	Typical (12)

(continued)

Table 4. (continued)

Domain	Themes	Frequency (n)
Suggestions for Improving Mental Health Services		
Solutions that participants believed would improve therapeutic experiences.	Increase disability-related knowledge	Typical (20)
	Be mindful of accessibility needs	Typical (14)
	Trust the client's experience of disability	Typical (12)
	Implement foundational clinical skills	Typical (12)
	Process life with physical disabilities	Variant (7)
	Integrate intersectionality	Variant (4)

Note. $N = 24$. General = 23–24 cases; Typical = 12–22 cases; Variant = 4–11 cases.

Indian and Latinx, bi/pansexual woman in her 30s, with a mobility impairment and chronic illness) described one straightforward intervention that was helpful to her, noting, “[My MHP] wrote a letter letting [my work] know that I had a disability, and that was great because I was able to use that as evidence later on—that my employer was made aware of my condition.” Some participants also reported that MHP responsiveness to their disabilities led to greater disability acceptance.

Nonspecific Positive Therapy Experiences. Three-fourths of participants described their psychotherapy experiences as generally beneficial, positive, and helpful. These experiences included feeling satisfied and connected with their MHPs and having a high level of trust in psychotherapy. Irene explained:

I’ve been in therapy since I was 15 and now I’m 41, so I’ve seen a myriad of therapists... Overall, it’s been a very positive experience in the sense that it’s a little bit guided. I’m a very introspective person in general, but it helps me [be] a little bit more guided—almost to have somebody to hold you accountable.

Managing Physical and Psychological Symptoms. The majority of participants stated that therapy helped them to lessen depressive symptoms, understand and alleviate loneliness, and overcome fears of future physical deterioration. Some participants said their MHPs guided them to accept their physical and contextual realities, and to learn self-soothing techniques to manage physical and psychological symptoms. One participant, Olivia (White, demisexual² nonbinary person in their 20s, with a mobility impairment and chronic illness),

described a useful, concrete approach to address physical symptoms, stating, “Right now we’re doing a pain log to see if there are any triggers for my pain, and that’s nice. And we’ve been working on my hand pain and she’s been helping me figure out solutions... like ergonomic pens.”

Christina (White and Latinx, heterosexual woman in her 30s, with a mobility impairment and chronic illness) shared how psychotherapy helped her psychological symptoms to improve:

[My MHP was able to] help me work through having a diagnosis of an incurable disease and becoming okay with that, and also being okay with others not being okay with that... In therapy, I’m seeing a bigger picture. I don’t see a dark hole. I see a bright light.

Self-Disclosure of Disabilities. Almost half of participants expressed that it was helpful or validating when their MHP disclosed their own disability experience. A statement by Lauren (White, bi/pansexual woman in her 20s, with a mobility impairment) reflected this experience:

When [my MHP] told me about her experience with having diabetes, it was really easy to connect and relate. [My MHP] sharing her own experience really helped me open up too because then I felt like I could share more about how I was feeling... I felt more safe in the room.

Domain 2: Negative Therapeutic Interventions and Interactions

This domain refers to negative counseling or psychotherapy experiences, or instances when an MHP employed clinical interventions that were inappropriate, unhelpful, or nonaffirming. Themes include avoiding a participant’s disability or other disability topics, inflexible or inappropriate responses, and attributing physical disability to psychopathology.

Avoiding Disability Topics. Almost all participants described MHPs avoiding disability-related topics in psychotherapy. Avoidance was due to MHPs’ failure to initiate disability-related dialogue or the participant’s unwillingness to broach the topic. In the latter case, the participant typically anticipated that the MHP would invalidate or not understand their disability experiences due to previous interactions with MHPs or nondisabled others. Madison (White, “questioning” woman in her 20s, with a mobility impairment and chronic illness) explained, “We didn’t really talk about my disability. We didn’t talk about the health side. It was just all about emotions and anger, and I didn’t feel heard at all.”

Kel (American Indian and White, bi/pansexual woman in her 40s, with visual, hearing, and mobility impairments, and chronic illness) said:

I felt like [MHPs] didn't want to approach [the topic of disability] at all. I really felt like, in therapy, any time I tried to discuss anything that was happening with my physical sicknesses, it wasn't heard. I would be pushed through the topic, or placated, or there was never any true targeting of those issues—never.

Invalidating Disability Experiences. More than half of participants reported that MHPs directly invalidated their disability experiences, including questioning the validity of physical symptoms, dismissing symptom severity, or implying superior knowledge of the disability. Vanessa (American Indian and Latinx, homoromantic asexual woman in her 20s, with a mobility impairment and chronic illness) described:

[My MHP] has talked before about life after I get better, and the thing is that, there's no getting better... He's been like, "Oh, in 10 years you'll be doing this and that, or traveling and this and that." Well, I may not be... and I've communicated that fear to him. And it's kind of been like, "Oh, well, you don't know. Don't get worked up about it."

Responding Inflexibly or Inappropriately. More than half of participants stated that their MHP lacked knowledge about disability issues overall, and were unwilling to educate themselves about the participant's specific physical disability. Experiences in this theme often included the MHP recommending inappropriate medical treatments, making prejudicial comments, or lacking disability accommodations, such as not providing allowances for disability-based cancellations. Althea (multiracial, graysexual³ nonbinary person in their 30s, with a mobility impairment and chronic illness) reported:

[My MHP and I] were talking about my partner, and we were talking about how we weren't going out very much—we stay home a lot. She asked me if I thought that it was because he's embarrassed to be with me. In my head I was like, "I don't know where that came from," because we hadn't discussed anything near that. He's very proud to be with me and is very comfortable being with me in public. So I had no idea why that would come out of left field... It was hurtful. At that moment I had to process the question itself and trying to be like, "Well, is that the case?" And then I came to the conclusion that no, it's not.

Participants frequently described experiences in this theme as harmful. For example, Nora (Latinx, bi/pansexual nonbinary person in their 30s, with a chronic illness) stated:

The way that [my MHP] spoke to me about being late wasn't considerate of something I had already divulged was a problem that I was beating myself up for—one that is a deep shame. After that, I was like, I don't want to go to that

person, because I don't like that. As much as I understand the importance of going places on time, because I'm an adult, that wasn't the support that I needed... It just made me feel shame, and it's already a lot to be vulnerable in that space. I would have just wanted a little bit more compassion.

Some participants also expressed discomfort or dismay because MHPs became visibly overwhelmed or distressed by their disability. Rachel said:

So this was a therapist I saw once as an initial appointment... I started telling her about some of my experiences and she literally started crying. I was like, "Listen, if you can't cope with my life, how are you supposed to help me cope with life?"

Finally, more than one-fourth of participants reported that their status as a disabled woman affected their experience in psychotherapy. A few of these participants said that because of their gender, their MHP questioned their disability or did not believe their physical symptoms were real.

Nonspecific Negative Therapy Experiences. Almost half of participants voiced an overall lack of trust and confidence in psychotherapy due to a history of negative experiences with MHPs. Kel said, "I've never really found somebody that I felt was honest, trustworthy, and really interested in helping me get better—not just sitting there for an hour writing in their tablet, doodling."

Attributing Physical Disability to Psychopathology. One-third of participants described instances in which MHPs suggested that their physical symptoms had psychological etiology, including somatization of anxiety and depression, drug-seeking, or an eating disorder. For example, Jessica (White, asexual woman in her 20s, with a mobility impairment and chronic illness) stated:

[My MHP] was saying, "Well, it could be psychosomatic. What if your neurologist is right?" And I was just like, "My legs don't work and I have a headache now constantly. I don't think I'm depressed."... I understand, yes, psychosomatic disorders are real and there's nothing wrong with that, but that wasn't what was wrong with me.

Worsening Physical or Psychological Symptoms. One-third of participants reported that negative experiences with MHPs exacerbated their physical or psychological symptoms. For example, some participants shared that mindfulness increased their attention to and experience of physical pain, which typically led to increased anxiety.

Domain 3: In/Accessibility of Services

This domain refers to participants' ability or inability to access mental health services. Themes include inaccessibility of psychotherapy services, including inadequate insurance coverage or high costs, poor physical setting of the provider's office, barriers to scheduling or finding MHPs, and transportation or parking problems. Participants also shared positive experiences, such as MHPs being willing or attempting to enact disability accommodations.

Inaccessibility of Psychotherapy Services. All but one participant described challenges with accessing mental health services. Four subthemes pertaining to specific barriers were identified.

Inadequate Insurance Coverage or High Costs. The majority of participants stated that the largest barriers to accessing mental health services were cost and insurance coverage. Most participants said their insurance would not cover the cost of therapy, or they were unable to find a MHP who accepted their insurance. As a result, many participants paid for mental health services out of pocket. Mercedes stated, "It would be super hard to find someone that would take [insurance].... That's been the story, where I'd call doctor after doctor after doctor and they didn't take it. So, it has been really hard."

Poor Physical Setting of the Provider's Office. Two-thirds of participants discussed barriers to accessing the MHP's office or building, including tightly configured waiting rooms and offices, and lack of elevators or ramps in the building. Althea said:

The office is a converted house so there are issues that come along with that... The house, of course, is on a hill so the first and second floors are split a little bit. They created a ramp into the main floor so they gave me somebody who was on that first floor, but I have to navigate really uncomfortably. I really don't like waiting in the reception area because there isn't space for a wheelchair... Then her actual office is a little bit better. I mean, there is space for me to feel comfortable wiggling into, but it's mostly [taken up by] big comfy seats. I have to wiggle myself between one of those seats and the door. So, it's not the most ideal at all.

Barriers to Finding or Scheduling Therapy. Almost two-thirds of participants reported barriers to finding an MHP due to a lack of local professionals or those accepting new clients. Some participants shared that MHPs did not answer or return phone calls, which impeded scheduling or rescheduling appointments.

Barriers to Transportation or Parking. More than half of participants reported that transportation was a barrier to mental health services, including difficulties securing a ride to appointments. When participants drove themselves, they often had difficulty finding nearby parking. A few participants reported traveling long distances to see their MHP. Kel stated, “Getting to appointments was very difficult. Public transportation is not set up for people like me... I would skip a lot of appointments because I didn’t have a safe and comfortable way to get there.”

Accessibility of Psychotherapy Services. At the same time, a majority of participants identified accessible aspects of mental health services, including the physical setting (e.g., elevators, wheelchair accessible), handicap parking, and insurance coverage. Describing her MHP’s office building, Amy (White, heterosexual woman in her 40s, with a mobility impairment and chronic illness) said:

Well for one thing it’s flat—the parking lot and everything is flat. But aside from that, [the building] is a more open space. When you walk in the door, not that it’s a huge waiting area, but the doors themselves are a wider door that would accommodate a wheelchair, and the hallway is wide... they’re big enough that you can maneuver a wheelchair or a walker. It’s definitely probably [Americans with Disabilities Act] compliant.

Willing or Attempting to Accommodate. Half of participants described their MHP as flexible and accommodating because they worked to create more accessible services and address accessibility needs. For example, meeting in alternate locations, offering sliding scale fees, rearranging office furniture, and rescheduling appointments without a fee when disability symptoms interfered with attendance. Kayla (White, bi/pansexual woman in her 20s, with a mobility impairment and chronic illness) said, “[My MHP] is really sensitive to what my needs are on a given day because my chronic pain fluctuates. She will set up pillows and blankets on the floor because sometimes that’s more comfortable for me than the chairs.”

Domain 4: Suggestions for Improving Mental Health Services

This domain refers to participants’ recommendations for improving mental health services for people with disabilities. Themes include increasing knowledge about working with disabled clients, being mindful of accessibility needs, trusting the client’s experience of disability, implementing foundational clinical skills, helping to process thoughts and emotions about having physical disabilities, and integrating intersectional identities.

Increase Disability-Related Knowledge. Almost all participants wished for their MHP to be more knowledgeable about their specific disabilities and people with physical disabilities in general. Some participants stated that MHPs should take initiative to educate themselves on disability visibility, ableist assumptions and microaggressions, treatment options and suitability, and variations in disability presentation among clients. Christina shared that she wants MHPs to “have an understanding of the patient’s disability. If you don’t know about it, maybe research a little bit, so you can maybe understand their level of pain, suffering, just *anything* [emphasis added]... Do a little research is all it is.”

Sam (Asian American, asexual nonbinary person in their 30s, with a chronic illness) was more specific:

I hope that all therapists can read up on [critical disability studies], because in my previous sessions, I feel like [MHPs] were always trying to cure me. Now my current therapist is actually saying, “No, you have all the right to feel anxiety,” or, “Your body pain is okay.” It’s like they’re moving towards a model of accepting who I am, instead of like, “We need to get you on meds. We need to get rid of this,” kind of thing... So it’s like seeing [disability] more as environmental and historical and social, instead of just the person with a disability—that it’s all our fault, or that it’s on us only to make the world more accessible. They’re saying no—that it’s a lot of things that are happening, multiple players and multiple dynamics that shape our disabilities, and that limit our participation, and it’s not only up to us, it’s up to everybody.

Be Mindful of Accessibility Needs. A majority of participants wished for their MHP to be more mindful of their accessibility needs, such as building/office accessibility and transportation. Some of these participants wanted MHPs to ask about their accessibility needs. Kayla had some specific advice for MHPs:

Something helpful to do differently is just ask, “Is this space accessible to you? Are there any things I can do to make this more accessible for you?” One example is my therapist always has an essential oil diffuser, and I like that, but some people are really sensitive to scent with certain disabilities. So, especially with your first therapy appointment, that might not be something that someone’s necessarily comfortable pointing out. So, I think having a therapist or a receptionist ask, “What can we do to make this as accessible as possible to you?” That would be really great.

Trust the Client’s Experience of Disability. Half of participants wanted MHPs to be more trusting of their disability experiences and not make assumptions about their conditions. Vanessa explained:

Disabilities take different forms. Be prepared for some who looks very able-bodied to come in and say that they're not, and to believe them and that they mean it. I started off not having to use a cane, and now I do. Now I am a lot less able-bodied than before. [MHPs] have to realize that in people's lives, it's not just a one stop, like, *this* [emphasis added] is a disabled person—this is how they're going to look and that's how their life is going to stay. Conditions progress, new medications get introduced. Someone's life could get better. It could get worse.

Participants also wished for MHPs to understand that clients are the experts on their own bodies, symptoms, and needs. To this point, Alison (White, heterosexual woman in her 30s, with a chronic illness) said, "We live in our bodies so we know best. We're not bulls**ting, you know, we know what's going on. We are the ones that are experiencing it."

Implement Foundational Clinical Skills. Half of participants wanted MHPs to better implement foundational clinical skills, such as listening, patience, nonjudgment, empathy, and validation. Jessica stated:

I wish I had been met with more empathy but not being too sympathetic, if that makes sense, because that can come off condescending... Instead of "Wow, that sounds really terrible," maybe more like, "Well, it sounds like you're in a lot of pain. Can we talk about that pain?"

Process Life With Physical Disabilities. More than one-fourth of participants wished for MHPs to ask more questions about experiences of living with physical disabilities, such as exploring how physical health or impairments affect other parts of life. Madison stated, "I wish that my therapist would ask me about isolation more, because loneliness is like one of the major side effects of being a disabled person."

Integrate Intersectionality. Several participants said it was useful to discuss their multiple cultural identities and/or intersecting experiences with oppression. These participants wanted an MHP with cultural competencies for working with diverse groups. Some of these participants stated that MHPs should seek education on intersectionality, and be willing and prepared to discuss it with clients. Vanessa stated:

The theme to my experience in therapy has been that there are providers who are well-versed with one population and that's it... Like if you have trauma, but you're also disabled and a person of Color, they don't know how all of those intersect.

Discussion

In this study, physically-disabled mental health consumers described their experiences in counseling or psychotherapy through individual interviews. Participants' willingness to share positive and negative experiences, along with their perspectives on best practices for working with disabled clients, provide a rich foundation to further develop disability-affirmative psychotherapy approaches and guidelines. To our knowledge, this is the first qualitative study to singularly focus on physically-disabled people's experiences in psychotherapy. The current research provides insiders' perspectives on what MHPs should know, believe, say, and do, in order to hold and convey a disability-affirmative stance. Thus, the present study meets calls to center disabled people in psychotherapy research (Olkin, 2017), and allows disabled people to guide clinical practice and future scholarship.

Viewed with a wide lens, the current results are consistent with previous literature on affirmative therapies. Zooming in, participant responses suggest that to provide disability affirming psychotherapy, MHPs should take a stance and approach that aligns with values of disability culture. Disability culture is described in different ways, by different scholars (see Olkin, 2017 for a review), but may be a useful lens with which to interpret the current findings and consider their implications. Gill (1995) published a list of values within disability culture, including acceptance of human diversity, interdependence, and vulnerability; tolerance for unpredictability with a capacity for complex future planning; a flexible approach to tasks while managing many moving parts; perceptiveness in interpersonal communication; and an unrelenting sense of humor. It is possible that, in some circumstances, participants had negative experiences in psychotherapy when their MHP did not understand, account for, or respect disability cultural values. On the flip side, when participants found psychotherapy helpful, there was often an alignment between disability cultural values and the MHP's approach, such as acceptance of diversity (see Sam, p. 21), shared vulnerability (see Lauren, p. 16), and flexibility (see Kayla, p. 20).

Further, a disability culture framework (Gill, 1995) may help to create pathways for greater cultural competency and humility when providing psychotherapy to disabled clients. Disability cultural competencies and humility require nondisabled MHPs to reflect on their nondisabled privilege and inherent ableism in their work. MHPs with disabilities can also reflect on their internalized ableism. Importantly, a disability culture framework combined with active self-reflection may allow MHPs to affirmatively explore disability culture and community with clients, which is a component of D-AT (Olkin, 2017).

Affirmative or Helpful Therapy Approaches

Many participants reported positive interactions and experiences in psychotherapy, which is consistent with previous research (Hunt et al., 2006), and may speak to the benefits of psychotherapy for disabled people. In both the online questionnaire and interviews, most participants reported positive feelings overall about their psychotherapy experiences. Although encouraging, these reports should be interpreted carefully. This study does not provide rates of helpful versus unhelpful experiences, and the results may be an artifact of a sample willing to participate in research interviews.

With this in mind, positive and helpful therapy interactions were built on a foundation of basic counseling skills. The importance of basic skills is also found in previous literature on affirmative therapies, such as with LGBTQ+ and transgender populations (e.g., Israel et al., 2008). In this study, trust, validation, and responsiveness to clients' disability-related concerns were fundamental to participants' sense of safety and a strong therapeutic relationship. At the same time, MHPs must avoid common ableist micro-aggressions, such as not minimizing the disability experience (see Vanessa, p. 17), and accepting that the person has a physical disability (see Jessica, p. 18).

These foundational counseling skills dovetail with a nonableist stance to create an affirming space for disabled clients. With a disability-affirming MHP, participants described psychotherapy as helpful for accepting physical impairments and limitations, building an affirmative disability identity, and coping with stress and prejudice. When psychotherapy targeted disability identity development, sense of self, self-compassion, and self-efficacy, participants experienced noticeable improvements in their assertiveness, self-esteem, self-advocacy, and personal growth. Olkin (2017) describes an affirming stance on disability as essential to D-AT, which this study supports.

Another central component of helpful psychotherapy was MHPs' demonstrated knowledge about disability or taking initiative to educate themselves about the client's disabilities or disability in general. Active learning and curiosity convey an understanding that disability is an important part of the client and, potentially, the psychotherapy. These findings support previous research (Hunt et al., 2006) and are reflected in D-AT (Olkin, 2017). A core tenet of D-AT is knowledge and active exploration of nine specific disability-related areas of the client's life and context that require disability knowledge and disability comfort. Disability comfort refers to an aspect of cultural competence with disability populations, referring to the provider feeling comfortable with disability in its physical form and unafraid to discuss aspects of life as a disabled person.

It is important to note that most participants faced barriers to accessing mental health services. When MHPs willingly accommodated disability-related needs, such as by pre-arranging a flexible appointment schedule or

rearranging office furniture for clients using a wheelchair, participants reported feeling understood and valued. Thus, MHPs need to be mindful of accessibility needs regarding the physical setting of their office and/or building, insurance coverage and cost of services, transportation and parking, and scheduling for appointments.

Harmful or Oppressive Therapy Approaches

MHPs were not immune to making negative judgments about physical disability and engaging in harmful practices that reinforced ableism. In fact, most participants described negative experiences with MHPs, supporting the contention that some providers hold ableist biases (APA, 2022). MHPs' dearth of disability knowledge and comfort has been described in earlier research (Hunt et al., 2006), and appears to be a consistent problem.

Participants described a concerning lack of disability awareness and knowledge among MHPs, as well as little initiative to educate themselves. A disabled client can interpret this lack of awareness, knowledge, and initiative in many ways, such as signifying a belief that disability is unimportant, bad, or shameful. Moreover, lack of disability awareness can contribute to invalidation of disability-related experiences, as reported by some participants. One example is when MHPs conceptualized physical disabilities as psychosomatic mental health symptoms (see Jessica, p. 18), even when medical diagnoses explained the symptoms and participants disagreed with their interpretation. Although the physical body can be used as a site for mental health treatment, especially in somatic and behavioral therapies, it is problematic to assume that physical symptoms are psychosomatic.

The results also showed that MHPs often fail to acknowledge or address physical disability, or avoid disability topics altogether. Rather than denying or ignoring the disability, an MHP with an affirmative stance believes the client about their disability, which allows for a corrective and healing relationship. Avoiding disability topics may reflect a lack of disability comfort and gets in the way of affirming practice.

Similarly, inaccessible offices and services were common, as participants faced physical, financial, and logistical barriers to mental health treatment. These reports are consistent with earlier research (Hunt et al., 2006) and represent overt ableism. Specifically, participants reported parking spaces far from the entrance, sets of stairs without ramps or elevators, and cramped offices with narrow hallways. They also reported financial and insurance obstacles, which are heightened among people with disabilities who are disproportionately poor and un- or under-employed (Brucker et al., 2015). Another barrier was MHP inflexibility regarding appointment scheduling, including lecturing and chastising clients about being late or canceling sessions (see Nora, p. 17). Instead of finding creative solutions for disabled

clients who experience inconsistent symptom severity, some MHPs interpreted attendance issues as not taking psychotherapy seriously. Such reactions and interpretations often exacerbated clients' physical and psychological symptoms, such as pain and anxiety. Participants said that it was helpful when providers allowed for phone or online sessions as needed.

Some participants were reluctant to discuss disability-related matters in psychotherapy, due to fear of prejudice or otherwise inappropriate responses. Examples include MHPs crying or overly sympathizing with disabled clients, providing "cures" for the disability (e.g., spirituality, herbal medicine), or being overly positive rather than helping to realistically manage disability-related distress. These findings provide further evidence that harmful microaggressions occur within psychotherapy (Mazzula & Nadal, 2015), and MHPs commit ableist microaggressions against disabled clients (Hunt et al., 2006). Thus, clients with physical disabilities might not initiate dialogue about important topics or connect their presenting concerns to their disability. Although important to "meet clients where they're at," it is also essential to routinely ask questions about disability at intake and throughout treatment (see Olkin, 2017 for a more thorough discussion of how to ask disability-related questions). Regarding the present study, it is worth noting that the results may be incomplete because some participants avoided disability topics in psychotherapy.

Finally, some participants stated that mind-body interventions brought attention to their physical pain in unhelpful ways, including mindfulness, meditation, and relaxation. Conversely, other participants described these techniques as helpful. Effectiveness of mind-body interventions likely depends on MHP training and skill in using such techniques with disabled clients, individual client factors and the nature of their disabilities, and the specific approach employed. There is scant research on this topic, but mindfulness has been shown to be helpful for people with physical disabilities (Swain et al., 2020). The current results should not be taken as evidence for or against the usefulness of mind-body approaches with disabled clients.

Unique Disability-Related Concerns

Participants discussed a multitude of life challenges related to or exacerbated by their physical disability, such as ableist microaggressions and minority stressors, un- and under-employment, financial difficulties and poverty, increased daily stressors, chronic pain, mobility impairments, and depression. Many participants described negative judgements from others about their disabilities, which in turn contributed to internalized ableism. These findings are consistent with previous research demonstrating mental health disparities among people with disabilities (Meltzer et al., 2012; Turner et al., 2006), and

the connection between mental health concerns and ableism (Conover & Israel, 2019; Green, 2003; Mazur, 2008; Turner & Turner, 2004).

Limitations

Although the participants in this study represented some diverse identities, the findings and implications are limited by the characteristics of the sample. First, the sample consisted overwhelmingly of cisgender women; although actively recruited, no men participated in this study. Men are less likely than women to participate in psychotherapy (National Center for Health Statistics, 2021; Watkins, 2012), and research (Watkins, 2012), which may have contributed to the gender discrepancy. Further, the sample was primarily White, and all types of physical disabilities were not represented, which limits the breadth of experiences. Finally, older adults were not represented, and there might be unique considerations for psychotherapy with older adults with disabilities.

Researcher Team Factors. To some extent, the participant sample reflected the demographics of the research team. Recruitment took place primarily on Facebook using personal accounts, so people who agreed to participate may have felt more akin to the researchers, and other voices may have been left out. Further, data collection and analysis were limited by the nondisabled status of three team members and similar type disability shared by two members. Researchers with other types of disabilities might have asked different follow-up questions, or had stronger rapport with some interviewees, potentially leading to deeper or divergent participant disclosures. In data analysis, participant statements might have been interpreted differently by researchers with other disability experiences.

Additionally, all research team members joined the project with an explicit social justice leaning, along with a belief that MHPs often do not provide disability-affirmative treatment. Like in all studies, the researchers' point of view influenced the research and interview questions, interviewer responses to interviewee statements, and analyses. For example, when participants discussed negative experiences in psychotherapy, the faculty interviewer applied her skills as a psychologist to encourage participant sharing, while attempting to avoid leading follow-up questions. It is possible, however, that interviewer verbal and nonverbal behavior unintentionally encouraged participants to expand on stories that verified existing biases.

Implications for Practice, Advocacy, Education/Training, and Research

Practice and Advocacy. People with disabilities make up a sizable portion of the United States population (Okoro et al., 2018), and are more likely to receive mental health treatment than nondisabled people (National Center for Health Statistics, 2021). Thus, regardless of setting, MHPs should expect to work with physically-disabled clients. The current study contributes several high priority implications for affirmative mental health services with disabled clients.

To begin, MHPs should learn about minority stress theory (Meyer, 2003), and consider its use in case conceptualizations to better understand the social, cultural, and contextual factors contributing to disabled clients' distress and dysfunction. Minority stress theory can serve to guide treatment interventions that help disabled clients to recognize, heal from, and cope with ableism, which may benefit mental health. Moreover, this orientation views disability as neither good nor bad, but rather a naturally occurring part of the human experience, which allows the MHP to more closely meet a client where they are.

Further, MHPs should learn about ableist microaggressions, especially those commonly made in psychotherapy (see Olkin, 2017). For example, it is harmful to assume that physical health symptoms are manifestations of psychological problems, or that clients with invisible physical disabilities do not experience impairment. Similarly, MHPs should ask clients about whether to center disability-related topics in session, rather than making this decision themselves. In the present study, ableist microaggressions negatively affected participants' sense of safety and the therapeutic alliance. It is important for MHPs to minimize ableist microaggressions, and to solicit feedback from clients to better detect when a rupture has occurred (Miller et al., 2013). When therapeutic ruptures occur, MHPs must apologize and attempt to repair the alliance.

Clearly, MHPs and mental health service organizations should prioritize accessibility when selecting and designing their spaces. The first step is to learn about what makes a space accessible or not. For offices, MHPs can use accessibility checklists based on the Americans with Disabilities Act (ADA), which are widely available online. MHPs should also seek guidance to ensure that all forms of communication and handouts are accessible. Other ways to increase equitable access include offering phone or video appointments as needed and providing longer but less frequent sessions.

Finally, the current findings point to ways that MHPs and nonpracticing psychologists can advocate for disabled people and clients. For example, MHPs can enact initiatives to increase physical accessibility at their workplace, as well as audit policies and practices to ensure accessibility for clients

with physical disabilities. Led by disabled psychologists and MHPs, there is a long history of disability advocacy within the field of psychology. Examples of current advocacy include the work of APA's Division 22 (Rehabilitation Psychology), APA's Committee on Disability Issues in Psychology, and the Disability Advocacy and Research Network. Nondisabled MHPs are encouraged to get involved in existing groups and organizations as appropriate, and follow the leadership of disabled people in their advocacy.

Education and Training. Targeted education and training are necessary to develop disability-specific knowledge, comfort, humility, and cultural competencies, which are essential to affirmative services. For example, MHPs need to seek continuing education about the disability experience, types of disabilities, differences across disability severity and visibility, their clients' specific disabilities, and how to increase office space and service accessibility across a variety of disabilities. Further, it is critical for MHPs to recognize and unlearn ableism, in order to help disabled clients to develop a positive disability identity and coping strategies for an ableist society. Thus, MHPs and trainees must gain disability-specific education and training to build affirmative practices for physically-disabled clients. Trainees, supervisors, and MHPs may benefit from articles and books on disability cultural competencies and D-AT (see [Andrews, 2020](#); [Artman & Daniels, 2010](#); [Dunn & Andrews, 2015](#); [Olkin, 2007, 2017](#)), as well as disability training videos (see [APA, 2012](#); [Post-Polio Health International, 2019](#)).

For students, graduate programs must integrate more required and elective coursework and workshops on disability ([APA, 2022](#); [Artman & Daniels, 2010](#)). For example, academic departments can and should increase the attention given to disability in foundational diversity courses, develop electives on disability psychology, and host guest speakers on working with disabled clients. To do so, programs must prioritize hiring and retaining disabled faculty, as well as faculty with a focus on disability. Further, clinical training programs can and should develop relationships with practicum sites where students have the opportunity to work primarily with disabled clients, and to develop their disability cultural competencies.

In sum, all clinical graduate programs, clinical practicum sites, conference planning committees, continuing education developers, and diversity trainers can and should take active steps to increase training opportunities in disability psychology and D-AT (see [Olkin, 2017](#)).

Research. The present study highlights several topics for future research. To start, at this time, no empirical studies have aimed to solidify aspects of D-AT and further research is warranted. Researchers are also encouraged to conduct more qualitative and quantitative studies on psychotherapy with physically-disabled clients in general. Quantitative studies with larger samples would

allow for generalizability of findings. Other qualitative methods, such as focus groups, could help to reveal additional disability-related experiences and important considerations for psychotherapy. Regarding specific psychotherapy approaches, some participants mentioned mindfulness, cognitive-behavioral, and trauma-informed therapies as useful. These results point to an opening for research on tailoring existing approaches to affirmative work with disabled clients. Further, empirical research needs to be conducted on effective disability competency training MHPs. Additionally, several participants described negative experiences with medical providers, so research in this area is warranted.

Finally, future studies would benefit from specific attention to disability subpopulations, such as men, LGBTQ+, and people of color. Men in general are less likely than women to participate in psychotherapy (Watkins, 2012), and no men volunteered to participate in this study. Thus, it seems useful to explore potential unique barriers for disabled men in utilizing mental health services and ways to address them. Similarly, future psychotherapy research should examine whether the present findings extend to disabled men's experiences in psychotherapy. Additionally, we must consider that disabilities are more common among LGBTQ+ communities and communities of color (Bernert et al., 2012; Fredrikson-Goldsen et al., 2012; National Center for Health Statistics, 2021). In the current study, LGBTQ+ people were not specifically targeted for recruitment, yet there was a high proportion of LGBTQ+ participants in the sample. In response, we encourage future mental health research focused on LGBTQ+ disabled people and disabled people of color.

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Notes

1. The terms “people with disabilities” and “disabled people” are used interchangeably in this article in order to honor varying preferences for person-first and identity-first

language in disability communities, including among the participants of this study. For a more thorough discussion of person-first and identity-first language, please see [Dunn and Andrews \(2015\)](#), and for additional guidance, please see [APA Style \(2019\)](#).

2. The term “demisexual” refers to people who experience sexual attraction to another person only after forming an emotional connection with them ([Asexuality.org, 2021](#)).
3. The term “graysexual” refers broadly to people who identify with an asexual sexuality to some extent, but not entirely; they may be mostly but not exclusively asexual ([Asexuality.org, 2021](#)).

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