

Rhoda Olkin is the leading authority on disability inclusion in psychology, and this is her most comprehensive offering yet. Disability competency doesn't end with working with clients; it must be infused in clinician training, research, and advocacy. That is why all psychologists—and those who train them—should read this book.

—**Kathleen Bogart, PhD**, Professor, School of Psychological Science, Oregon State University, Corvallis

This text provides an extremely approachable, accessible, and comprehensive introduction to working effectively with clients with disabilities and their families. Readers will gain a strong understanding of the psychosocial experiences of people with disabilities, and how those experiences can impact the therapeutic relationship and process. This text will help prepare a new generation of culturally competent disability therapists.

—**Emily Lund, PhD, CRC**, Associate Professor, College of Education, The University of Alabama, Tuscaloosa

Building a Disability-Affirmative Mental Health Practice is an invaluable guide that every psychotherapist should have on their shelf. With clarity and depth, it illuminates how to create truly accessible, respectful, and empowering therapeutic spaces for clients with disabilities and chronic illness. This book is not only essential reading—it's a call to action for a more inclusive and just mental health field.

—**H'Sien Hayward, PhD**, Licensed Clinical Psychologist; Chair, American Psychological Association Committee on Disability Issues in Psychology

This accessible, personal, and deeply engaging book offers the essential history and modern context needed to build a disability-affirming mental health practice. Drawing on her lived experience as a disabled person since childhood and her expertise as a mental health professional, Olkin brings humor, unflinching honesty, and steadfast optimism to the challenges disabled people face today—leaving abled readers inspired to do better as allies and advocates. An easy read packed with pragmatic strategies and resources, this is a book you'll reach for time and again.

—**Anna L. Kratz, PhD**, Professor, Department of Physical Medicine and Rehabilitation, University of Michigan, Ann Arbor; Editor-in-Chief of the journal *Rehabilitation Psychology*

Rhoda Olkin is a gifted and person-centered practitioner, scholar, and advocate; her work affirms disability as a form of diversity, and is focused on and mindful of the needs of disabled clients and their families. This excellent book will ensure interested therapists develop the necessary clinical skills to promote the mental health, flourishing, and well-being of people with disabilities.

—**Dana S. Dunn, PhD**, Professor of Psychology, Department of Psychology, Moravian University, Bethlehem, PA; author of *On the Foundational Principles of Rehabilitation Psychology: Origins, Understanding, and Applications*

The author is a person with a disability herself and has experienced many instances of discrimination and marginalization. She emphasizes the disadvantages that many people with disabilities encounter because of the built environment and negative social attitudes. Being an ally of people with disabilities means using our privilege to help dismantle ableism, and counter structural ableism—to be actively alert to the barriers to full inclusion for individuals with disabilities, and to be mindful of our own privileges and of the challenges that individuals with disabilities face every day. This book will help mental health trainees gain an understanding of disability, and help push mental health training programs to increase the representation of clinicians with disabilities.

—**Fabricio E. Balcazar, PhD**, Professor Emeritus of Human Development; College of Applied Health Sciences; University of Illinois at Chicago

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Preface

My Personal Disability Story

I start with my personal history for several reasons. First, it is important to me that I am writing as a disability insider. Second, many elements of my history are universal in the disability community and echo things you will learn more about in other chapters. I feel passionate about helping those in mental health be more familiar and comfortable with disabled clients and hope that this book conveys some of that passion.

I had polio when I was an infant, 1 year before the vaccine became available. There were two isolated cases in Michigan, and I was one of them. This led to a core belief of mine that the unlikeliness of an event is no protection. The polio affected mostly my right leg, which is paralyzed from the thigh down. As I age, it has become apparent that other parts of my body were also affected that had been unnoticeable until now.

I was hospitalized for surgeries when I was 1, 3, 7, 13, and 16 years old. Being separated from my parents while in the hospital (in those times, parents were not allowed to stay overnight), I developed separation anxiety. I thought every passing car would kidnap me and I'd never get home again. To this day, I like to be the one to hold the car keys so that when others disappear off the face of the earth, I can still get home. I can articulate this irrational belief, even know its origins, yet it still has a hold on me.

Because of surgeries, I missed a lot of school. When we moved to Minnesota the playground was so far from the school building that I could not get there

and back, much less play, before recess was over. So I stayed by myself sitting on the steps; only occasionally would another kid decide to sit with me. The lesson was obvious: Disability separated me.

By third grade, we moved to California—in large part due to me: Poor circulation in my right leg made it susceptible to frostbite, and I had trouble navigating in the snow. In third grade, a boy with hemophilia was transferred to my class. The teacher made such a big deal about it that I learned by example that people with disabilities were fragile and should not be touched.

I wore a series of heavy leg braces throughout childhood. At age 13, after 2 years in “special PE” (with five other kids with disabilities completely different from each other), I took the brace off and refused to wear it. Although it was then harder to walk, it did show what my body was capable of without a brace. However, surgery would be necessary to stop my foot from landing on its side. At age 16, I had a triple arthrodesis, a procedure in which they broke the bones in the ankle and rearranged them (and yes, it was as painful as it sounds). I was out of school (again) for months; there was no home/hospital instruction option then.

Throughout my childhood, so many adults told me I was brave and courageous. This is a stereotype about disabled people—that we have extra fortitude to go through what to others looks very hard. But I never felt brave, because what choice did I have?

My first inkling of disability as diversity came when 30 Black students from the other side of town were bused to my almost all-White high school of 1,200 students. They stuck together as a group (duh!). I was surprised they greeted me by name, but then I was the only teen with a visible disability in the school. Were they telling me something? I was quite struck by how they had each other, which led me to ask, “Where is my group?” I didn’t find it for a long time.

I went to college before there were any laws to guide the institutions (e.g., Individuals With Disabilities Education Act [IDEA], Americans With Disabilities Act [ADA]). I had to educate every university I attended. At the University of Oregon, I got my own parking place with my name on it, but it was at one end of the campus, meaning I had to walk the distance of the campus. At Stanford University, I was told I could park in any legal spot anywhere (but there were no open spots). At University of California Santa Barbara I rode a four-wheel motorized scooter the 1 mile to campus and parked near the bicycles, then walked with crutches wherever I had to go.

As laws were finally passed, starting in the mid-1970s with the Education for All Handicapped Children Act (1975), now IDEA, and the Rehabilitation Act (1973; with sections 503 and 504 applying to all institutions receiving

federal funds, i.e., every college and university), one might assume that accessibility became guaranteed. This was not the case, nor is it even now, after the ADA (1990) and the ADA Amendments Act (2008). A few years ago, when the campus where I teach moved to San Francisco, I stopped the university president in the elevator and told him I was not coming back until he figured out where I was going to park. The distance between laws and enactment is a chasm that I hope the arc of history will span.

Having worn braces, used crutches for many years, moved to a motorized three-wheel scooter for many more years, and finally a power wheelchair since my 40s, I am well aware of how each assistive device garners different reactions from the public. When I walked with crutches I got asked a lot about why I used them, even from strangers just passing me on the street. I often lied in reply, anything from “I had a bike accident” to “I had a head transplant, and they are trying a new approach.” Lying about one’s disability is not uncommon, and when teens do this, we should not over-pathologize it. In a power chair, I get comments from nondisabled people such as “You’re going to get a speeding ticket,” “Don’t run me over,” and “I wish I had one of those,” each not realizing how often I hear this. The nature of microaggressions vary depending on the type of assistive technology, but the visibility of a disability aid seems to break down a social barrier, making it more likely that others will make a comment or a joke.

This recount of my youth is not meant to evoke pity. Despite incredible privilege (e.g., a father who was a university professor and thus I was treated at first-rate hospitals), I had a difficult childhood. But I am who I am because I am female, Jewish, a mom, and disabled. And because my disability onset was so early, I cannot conceive of who I would be without it any more than I can imagine not being female. Life did get better as an adult, as people assured me it would when I was a child. To be honest, being disabled is hard. I manage pain and fatigue on a daily basis, even more as I age. Just know that never once in my life did I wish not to be disabled, as it is so much a part of me. This may differ for clients with later-onset disabilities who have a before and after. But trust your disabled clients when they are more disability positive than you might think possible. We know that nondisabled people don’t want to be “like us,” but that doesn’t mean we are sad, depressed, unhappy, or wishing and waiting for a miracle cure. Mostly we are incredibly disadvantaged by the built and social environment and are waiting for society to change.

INTRODUCTION

A Clinical Guide to Gaining Disability Competence

In one of my classes I teach a graduate course on clinical interviewing skills. I start the first class by allowing my students to ask me any questions they want. I note that in 35 years, no students have ever asked me why I use a wheelchair. They perceive this question as more intrusive and personal. I suspect they are not alone in this view—two studies with disabled clients found that few clinicians raised the issue of disability first (Conover & Israel, 2019; Gomez & Olkin, 2024). It seems that, like my students, clinicians are reluctant to talk about disabilities. A key purpose of this book is to demystify and deconstruct disability to increase both knowledge and skills, as well as help clinicians feel comfortable with the topic.

WHAT IS A DISABILITY-AFFIRMATIVE PRACTICE?

What does it mean to be *disability affirmative*? It involves a reframing of disability as a common and ever-present feature of humanity, one which should be included in all aspects of creating equal spaces (e.g., education, communities, housing, employment, health care, politics). Disability is not a personal tragedy, and the needs of disabled people are not “special” but

<https://doi.org/10.1037/0000514-001>

Building a Disability-Affirmative Mental Health Practice, by R. Olkin

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civil rights. Disability-affirmative perspectives focus on the environmental and social context of the person, with an emphasis on how that environment creates barriers and disadvantages for disabled people. A disability-affirmative reframe does not essentialize disability as the primary defining characteristic but views all aspects of the person's identities as a mixture in which no one part can be separated. There is disability pride, which is not viewed as an oxymoron.

Although disability affirmation has been increasingly discussed since about 2015, these discussions have not filtered heavily into clinical practice. My book on disability-affirmative therapy (Olkin, 2017) was the first to bridge this gap. I developed a template of areas to cover with disabled clients to place the disability in the proper context of the client. Using this template would help clinicians neither overemphasize nor underestimate the role of disability in the person's identity, functioning, relationships and presenting problems. That book focused on what to do in the therapy itself. This is not that book. This is a broader book that covers more aspects of disability-affirmative practice, from signaling your attention to disability on your intake forms to how to be a disability ally and advocate.

GENERAL COMMENTS ABOUT THIS BOOK

This book is intended for those in the helping professions in mental health, regardless of degree or license type. There is no right or wrong way to approach this book. I intend it to be the thing you keep on your shelf and use as needed. You could read it straight through (good work, you!) or go to a specific chapter as an issue arises. Because I know you might be jumping around, I often refer to another chapter so that you will know where to go to learn more about an issue.

Many disability topics overlap, so where it might seem that I am overlooking something in one chapter (e.g., same-gender partners), I probably have that topic elsewhere. Thus, the index is your friend for quickly finding where a topic is discussed. Note too that I repeat some important information in more than one place, in case you are looking only at one chapter. So no, it's not déjà vu, you really might have read it before. It's repeated because many ideas are relevant in a few places.

I wanted this book to be easy to read. As hard as it was to abandon typical academic writing (sentence, two references, another sentence, three more references, etc.), I adopted what I hope is a friendly tone that invites you in. I do have references, as the book is empirically guided. And for some topics,

I give you suggestions for more reading. Also, I sprinkle in some of my own experiences as examples when I believe they are experienced by many disabled people. Sometimes I also provide some suggested initial questions to start a conversation with a client.

For most of this book, I use the term *disability*, but for a few chapters I use *chronic illness and/or disability* when discussing a group that may not think of themselves or their family member as being disabled. For example, many parents of disabled children refer to the disability by the name of the diagnosis (e.g., cerebral palsy, spina bifida, trisomy 21). “Disability” can be an identity as well as a condition, and not all clients will identify this way.

I am fairly certain I have left out important topics without meaning to. The field of disability spreads across different disciplines, including social psychology, rehabilitation psychology, anthropology, health care, literature, organizational psychology, political science, technology, and more. I am writing from the perspective of a clinical psychologist seeing outpatient disabled clients. This means I do not have the same training as someone in, say, rehabilitation psychology, which has much more training about moving people from rehabilitation centers into the community and getting disabled people into jobs. So although I can talk about issues of disclosure at workplaces, there is a vast literature on disabled workers that is outside my realm.

Nor can I pretend that this is the definitive guide to all things disability. Although I have personal, academic, supervisory, and clinical experience, it would be hubris to think I can cover all types of disabilities and all the clinical situations that might arise.

WHAT'S IN THE BOOK?

Here is an outline of what you'll find in this book. There are three parts: “Introduction to Key Concepts” (Chapters 1–5); “About Specific Populations and Intersectionality” (Chapters 6–13); and “Areas of Knowledge and Skills” (Chapters 14–21). Each chapter contains “Clinical Takeaways” and clinical examples. Appendices include measures for clinical use and self-assessment as well as practice vignettes.

Part I: Introduction to Key Concepts

Chapter 1, “Language: How We Talk About Disability,” discusses disability language: what is ableism and what are ableist terms, together with some alternatives to use in place of negative or derogatory terms. Chapter 2,

“Disability, Health, and Disability Disadvantage,” talks about what the term disability constitutes and distinguishes between disability and health. It includes discussion of the many disadvantages disabled people face. Chapter 3, “Making Your Practice Disability Accessible,” walks you through some disability-specific accommodations, what *accessibility* means in a clinical office, policies that are disability affirmative, and some resources for more information about specific disabilities. Chapter 4, “Conceptualizing Disability: Moral, Medical, Social, and Biopsychosocial Models,” introduces four models of disability; understanding these models is important in framing clinical work. Disabled clients and their families generally hold some combination of models, and each model has both positive and negative aspects. I posit that it is not fruitful to try to change clients’ models, but rather that we want to move clients to the positive aspects of their existing model(s). Chapter 5, “Disability Laws and Civil Rights,” gives the legal definition of disability in most laws, and reviews seven relevant laws. This is followed by a discussion of reasonable accommodations based on disability, distinguishes service animals from emotional support animals, introduces a resource (centers for independent living), and also addresses medical aid in dying.

Part II: About Specific Populations and Intersectionality

There are five chapters on disability within a family, depending on who in the family is disabled. Chapter 6, “Disability in the Family: A Systemic Approach,” makes the case for why disability is a family affair. I cover family information and beliefs, introduce concepts from medical family therapy (in which practitioners combine family therapy and working within medical systems), and show how one might help a family reframe a disability to reduce catastrophizing. Chapter 7, “Romantic Partners With Disabilities,” talks about interabled couples (one with and one without a disability). A difference is shown between partners who enter a relationship with one already disabled partner and those partnerships in which disability enters the relationship. The concept of relationship skew and disability boundaries are discussed, along with dating and sexuality and same-gender partners. Chapter 8, “Disabled Children and Teens,” focuses on the children themselves, together with four important tasks for them: ownership of the disability story, integrating the disability into self-identity, learning to manage others’ reactions, and launching from the family. Chapter 9, “Parenting Disabled Children and Teens,” switches the focus from the children to the parents raising them. Because there is so little guidance on ways of raising a disabled child, this chapter includes information for clinicians to help parents, how

to talk with their offspring, general principles, and what disability-affirming parenting might be. It touches on siblings of disabled children and includes tasks for parents and clinicians to help the disabled child. Chapter 10, “Disabled Parents,” gives some basic data, covers pregnancy and childbirth, and discusses the many barriers disabled parents face. Some potential positives for disabled parents are included, along with guidelines on how to decide if a child performing a specific disability-related task for their disabled parent is appropriate. Chapter 11, “Intersectionality: Disability in Context,” tackles the problem of essentializing disability such that it is studied out of context of all identities. When considering what we know about disability, the focus has been mostly on WEIRD (White, educated, industrialized, rich, democratic) populations, with some growing research in Asian countries with Confucian belief systems, leaving out whole swathes of the world. Discussion includes dimensions of culture, intersectionality (Crenshaw, 1989, 1991), and the ADDRESSING model (Hays, 2024). Some specific areas of intersectionality are highlighted, including age and generation, religion, ethnicity/race, socioeconomic status, Indigenous populations, gender, and veterans. Specific suggestions for clinicians and clinical examples are sprinkled throughout the chapter, including asking clients about their intersectional identities and developing cultural humility. Chapter 12, “Disability in LGBTQ+ Communities,” coauthored with Kristin J. Conner, continues the theme of intersectionality with a population that has higher-than-expected levels of disabilities. Issues of disclosure and finding community are included. Chapter 13, “Disability and Aging,” examines adults who acquire disabilities as they get older and adults who already have a disability that is impacted by the aging process, offering guidance for how to address universal challenges with aging as well as suggested resources for clients who are aging with a disability.

Part III: Areas of Knowledge and Skills

Chapter 14, “Disability Fatigue and Pain,” covers the two most common disability symptoms. The fear-avoidance model of pain and cognitions about pain are important in their management (A. H. Rogers & Farris, 2022). I offer alternative ways to measure pain and some pain management ideas. I describe ways to understand disability fatigue and tools for clients, along with some potential questions clinicians can ask. Chapter 15, “Assistive Technology and Devices,” shows the importance of assistive devices and technology (AT) in disabled people’s lives, whether very low tech (e.g., a grabber) or high tech (a computer app). Importantly, the interpersonal experiences will vary with the

type of AT used, and self-identity can change as well. Falls and fall prevention is a key impetus for some AT. Chapter 16, “Ableism and Microaggressions,” written with Kristin J. Conner, tackles a common occurrence for disabled people, and the management of microaggressions can be a critical area for clinicians to understand and treat. Chapter 17, “Disclosure of Disability,” is not a simple binary choice. Rather, disclosure is on a continuum of information levels, and disabled people encounter multitudes of situations in which they have to make decisions about disclosure of disability. The chapter includes questions to ask disabled clients about disclosure in any one specific circumstance. Chapter 18, “Assessment and Disability,” written with Hadas Pade and Julia Feinberg, who both have considerable assessment experience, is geared toward general clinicians who use some common measures in therapy (and not to those who conduct comprehensive assessment evaluations). Included is information on how to choose measures, make modifications to administration of measures, and understand reports written by others who did a more complete battery. The special issues involved in assessing depression in the context of disability and using measures with the Deaf (culturally and linguistically deaf people) are highlighted. Clinical examples show the complexities to be navigated. Chapter 19, “Disability Culture and Community,” outlines what disability culture is and how it is manifest in values and observable behaviors. Ways to help clients find their way to the disability community are included, along with the major components of disability culture and the disability rights movement. Chapter 20, “The Clinician’s Disability,” is for those clinicians with disabilities that may be readily apparent or may not be visible to others to think about disclosure themselves. Their own disability identity will be a factor in comfort and decision making around disclosure and about to which clients it would be clinically useful to disclose. Chapter 21, “Being an Ally and Advocate,” I close with a call to action, as clinicians often serve in multiple roles. Whether an instructor, mentor, advisor, researcher, supervisor, or other role, disability advocacy needs allies. Specific ideas are presented for various professional roles. Clinical issues are raised, along with a series of scenarios challenging readers to consider what they might do in those situations.

Appendices

The book concludes with seven appendices. The first six contain assessment tools you can use to assess clients’ disabilities or to assess your own skills and biases as a clinician. Appendix A is an Ableist Microaggressions Scale you can use with physically or sensory disabled clients to assess their frequency of microaggressions. Appendix B is a Disability Questionnaire Scale that you

can use with all clients to obtain information about any disabilities they might have, how their disabilities impact them, and what accommodations they need. Appendix C is a Beliefs About Disability Measure that you can use with disabled clients to assess their positive and negative beliefs associated with the moral, medical, and social models described in Chapter 4. Appendix D includes a Nondisabled Privilege Inventory that you can use to gain awareness of your own privileges and potential biases. Appendix E offers another self-assessment tool you can use to evaluate your own competence in working with disabled clients. Appendix F contains the brief Overall Quality of Life Measure, which can be used to evaluate a disabled client's level of satisfaction in five key areas of their everyday life. The final appendix, Appendix G, offers a set of clinical vignettes that encourage you to think about how you might approach clients with various disabilities and different perspectives about themselves in relationship to their disabilities. The vignettes also can be used if teaching about disability in a clinical course.

FINAL NOTE

All vignettes or clinical examples are fictional and are not knowingly about any people, students, or clients I have encountered. I am informed by colleagues, teachers, supervisors, students, and clients with disabilities and use some amalgam of stories from all of these and other sources to make up examples.

It is very possible to be disabled and yet hold negative intrinsic bias about disability. As much as I'm a fierce disability advocate, I show bias on Project Implicit's Disability Implicit Association Test (available at <https://implicit.harvard.edu/implicit/selectatest.html>; see also <https://www.projectimplicit.net>). Also, I came of age in the 1960s (yes, I'm that old!) when there were virtually no legal protections for disabled people. Those who grew up with early-onset disabilities and who went through school after specific laws were enacted had different experiences. The current ubiquity of blue wheelchair signage and parking spaces were nonexistent when I was growing up. Some causes of disabilities were mostly eradicated in the United States (e.g., polio), and others became more prominent (e.g., asthma and diabetes). Genetic testing during pregnancy became available (Tay-Sachs disease, trisomy 21/Down syndrome). The world has changed dramatically since World War II, and the political climate changes with it. What remains fairly unchanged is that disability is still a highly stigmatized attribute, and one that is a defining characteristic (i.e., the thing people notice about you that overrides many of your other facets).

I am not immune to prejudices. For example, I am a devout systems clinician—whether seeing individuals, couples, or families, I think of the system in which the disabled person lives. Also, I have a history of negative medical experiences that probably seep through in my current views. I hate the 1-to-10 pain scale and believe most clients do as well. And I may be wrong about a lot of things. My antidote to these perspectives is to be an empiricist with decent self-awareness who guards against imposing views on others and asks for your forgiveness when I err.