COUNSELORS' PERSPECTIVES ON DISABILITY: CHALLENGES AND SOLUTIONS IN THERAPY

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Abstract: The struggle for equality among individuals with disabilities parallels historical movements advocating for the rights of minority groups, yet it retains distinctive challenges and timelines. While prejudice, discrimination, and stigma are pervasive experiences among marginalized communities, the contemporary fight for equality by adults with disabilities stands as a unique endeavor. This paper explores the intersectionality of disability rights within the broader context of historical social justice movements, drawing parallels with the Women's Movement and racial integration efforts. While the Women's Movement traces its roots to the 1600s, gaining significant momentum with the Suffragist Movement in 1848 and reaching its zenith in the 1960s and 1970s, racial integration marked milestones such as the Brown v. Board of Education ruling in 1954 and the end of Jim Crow Laws in 1969. However, despite these advancements, children with disabilities faced educational segregation until the enactment of the Individuals with Disabilities Education Act (IDEA) in 1975, signifying a belated recognition of their right to equal educational opportunities. This paper illuminates the distinct trajectory of the disability rights movement, emphasizing its evolution alongside broader societal shifts and legal frameworks.
Keywords: Disability rights, Equality, Social justice movements, Individuals with Disabilities Education

INTRODUCTION

This qualitative study explores how clients perceive and experience counselors with visible disabilities. In particular, the study examines the topic of therapist disclosure with respect to one's disability and how disclosure relates to the therapeutic alliance.

As with many minority groups, the personal encounter with prejudice, discrimination, stereotyping, stigma, and segregation is common among those with disabilities. Yet perhaps the major distinction between those with disabilities and other minority groups is the more contemporary struggle for equality by adults with disabilities. The Women's Movement can be traced back to the 1600's, yet it is more commonly linked with the official start of the Suffragist Movement in 1848, and its peak in the 1960 and 1970's. The arena of racial segregation is typically highlighted by the academic integration victory via the Supreme Court ruling in the Brown vs. The Board of Education in 1954 and the end of the Jim Crow Laws in 1969. Despite such integration victories, children with disabilities were not legally entitled to equal education among their non-disabled peers until the 1975 establishment of, what is now called, IDEA (Individuals with Disabilities Education Act). The American with Disabilities Act (ADA) was not signed into law until 1990, prohibiting discrimination on the bases of disability in the areas of employment, academics, and social services. When it comes to striving for social inclusion the disabled population is perhaps the youngest minority community.

Despite recent gains in social awareness and equality and ADA requirements, the invisibility of those with disabilities remains common. We can witness this marginalization in daily social interactions (Sapey, 2004; Murdick et al., 2004), occupational opportunities (Krieger, 1977; Wedl, 1984; Lyons and Sullivan, 1998), academic institutions' admission practices (Olkin, 1999), political policies (Sapey, 2004; Deal, 2003), and scientific endeavors (Sapey, 2004). The psychological community too has dedicated relatively little attention to issues impacting those with physical disabilities (Glover and Janikowski, 2001). While racial and body shape discrimination have been addressed, precious few studies have examined the experiences of those with visible disabilities. Even fewer have addressed therapists with visible disabilities

(Liesener and Mills, 1999). This exploratory, qualitative investigation examines some aspects of clients' social perspectives on therapeutic rapport building when the clients are able bodied and the therapist has visible disabilities.

Extant psychological research on physical disabilities

One of the most developed areas of psychological research on discrimination is the field of multicultural counseling. Yet this literature seems ambivalent with respect to the inclusion of persons with disabilities as part of the multicultural discourse. Sue and Sue (2003), include a single chapter on counseling individuals with disabilities. Atkinson and Hackett (2004), include two chapters related to disabilities. Most other popular texts in the diversity field do not address the topic of disability at all (Aponte and Wohl, 2000; Axelson, 1999; Pedersen et al., 2002). Considering this is a discipline that focuses on marginalized populations, the absence of person's with disabilities in this discourse is noteworthy. To date, research on this topic is sparse, primarily focused on social biases that may influence the interpersonal encounter with a person with a visible disability.

From anxiety to otherness

Gathering perceptions, especially on topics that elicit anxiety is a challenge. All interpersonal encounters are potentially anxiety producing, and establishing an intimate and intense relationship may indeed be even more disquieting for some clients when they are working with a counselor with a visible disability. Hypothetically, some clients may be relieved, feeling less anxious when they realize that their counselor has endured and mastered a significant life challenge.

Liesener and Mills (1999) used the term, "disability spread" to explain the tendency of able-body people to attribute cognitive impairment to someone with a visible disability and thus speak with such a person in a loud, slow and simplified manner. Furthermore, in cases where the disabled individual is accompanied by a nondisabled companion, it is common for able-body individuals to talk to the person with a disability through the nondisabled companion.

They explained that it is common for able-body individuals to associate physical disability with both dependency and generalized impairment, including his/her emotional and cognitive abilities. Interestingly, Liesener and Mills (1999) do not attribute the dependency and impairment interpretation to stigma. Instead, they argue that the unique treatment of those with disabilities is based on perceived differences, noting that perceived differences may either enhance or impair the social acceptability of the individual. In order to emphasize this point, the authors turn to previous studies, (Belgrave and Mills, 1981; Liesener and Mills, 1999) which indicate that able body people will often rate someone with a disability more positively than his/her nondisabled counterpart.

Because both positive and negative attributes can be associated with individuals with disabilities, disability spread cannot simply be an outcome of negative views rather, it must stem from a defining characteristic that society has come to attach to disabilities and be impacted by exposure and education. Building on the notion of disability spread, Murdick et al. (2004) claim that prejudice towards the disabled is often an unconscious reaction that stems from the idea of "otherness," individuals with disabilities are treated as if they are different from the rest of society. Because individuals with disabilities do not fit into cultural definitions of "normality," they are perceived as deviant and subsequently marginalized. Placing this in historical context, Murdick et al. (2004)

demonstrated that attitudes towards the disabled can range from divine reverence, to embarrassment, from reluctant acceptance, to complete social exclusion. The authors note that in Western societies, individuals tend to judge "otherness" as something to be feared and shunned. Once seen a dependent, those with physical challenges do not seem to live a life compatible with the Western values of individualism and independence. Perceived differences, based on social constructs, have transformed impressions of the disabled into the pitiful and anxiety inducing "other." Such unfamiliarity may then easily transform into hostility, disregard, and disrespect. Having been defined as "other," the disabled are typically seen as not having "the same needs, concerns, wants, and desire"(Murdick et al., 2004) as the rest of society. When these assumed differences are emphasized, the "other" is no longer seen as person, and it is within this mindset that conscious and unconscious prejudice get justified and rationalized. Taking the authors' assertions slightly further, it becomes clear that, like all incidences of prejudice, the concept of otherness delineated by Murdick et al. (2004) are rooted in anxiety towards those who act, believe, live, or look different.

Self-disclosure

If those with disabilities may be categorized primarily based on the disabled characteristics, what social perspectives can impact counselors with visible disabilities and their clients?

In a review of studies of counselors with a disability, Mallinckrodt and Helms (1985) reported that there are both advantages and disadvantages for the clients. On the positive side, counselors with disabilities may be perceived as having better coping skills, serving as greater role-models, and being more empathetic by clients (Brearly, 1980; Grantham and Joslyn, 1981; al., 1979; Mallinckrodt and Helms, 1985). Conversely, such therapists may also be viewed more negatively than their able-body counterparts and face higher rates of client drop-out (Bowman, 1979; Dailey, 1977, 1978; Goldberg, 1974; Stovall and Sedlacek, 1981; Mallinckrodt and Helms, 1985).

Recognizing this dichotomy, Mallinckrodt and Helms (1985) attempted to find approaches for decreasing negative perspectives towards therapists with physical disabilities. They looked particularly at the role of self disclosure for counselors with observable and non-observable disabilities. One hundred and sixty-nine undergraduate volunteers were shown excerpts of a therapy session between an able-body female client and a counselor with a disability. One of the male counselors had an observable disability (that is being a wheelchair user). The other reportedly had an invisible condition (that is having a discreet visual limitation). Both counselors were shown in sessions in which they either disclosed or openly discussed their disability or in which they carried out the session without alluding to their disability. In general, subjects favored the counselors with disabilities. The authors attributed this tendency to the participants' assumption that due to some potentially difficult life experiences, counselors with disabilities had gained expertise in coping or had become more empathetic towards the struggles of others. There was no evidence supporting a negative impact of self disclosure on attractiveness and a slight enhancement for counselors with a non obvious condition. The authors concluded that with therapists with disabilities discuss their disabilities in order to enhance their therapeutic effectiveness and reduce "other" anxiety, particularly when working with clients who have negative attitudes towards those with disabilities.

As Mallinckrodt and Helms (1985) indicated their study, their research does not address the timing and frequency of optimal self-disclosure. Knowing the clinically ideal degree of disclosure can be pivotal, especially in light of prior studies that indicated that excessive self disclosure by a therapist can actually be harmful (Mann and Murphy, 1975; Simonson 1976; Mallinckrodt and Helms, 1985).

The generalizability of their study was limited since all of the counselors were Caucasian and the participants were college undergraduates. More importantly, the wheelchair-using counselors in this investigation were not actually disabled and thus they do not represent those with disfigurements. This may well have impacted the level of anxiety and ambivalence to be experienced by a client. The absence of interpersonal fear, anxiety, and social discomfort on the part of participants in this study is a notable limitation.

Exploring the extant literature to 1991, Miller summarizes the findings by indicating that physically disabled counselors can be perceived as having more empathy, unconditional positive regard, awareness of the client, genuineness, and congruence relationships (Mitchell and Allen, 1975; Mitchell and Frederickson, 1975; Toner and Johnson, 1979). Overall, such therapists may be seen by clients as more understanding and experienced in coping skills due to their own life circumstances. In fact, clients have been reported to show a preference for a counselor with a disability over an able-body therapist especially when dealing with more personal, serious, or threatening issues. In contrast, however, Miller (1991) reports that other studies indicate that both able-body and disabled individuals themselves hold negative attitudes towards those with physical disabilities (Allen and Cohen, 1980; Bowman, 1979; Cash, Begley et al., 1975; Noonan et al., 1970; Stiller, 1963; Stovall and Sedlacek, 1981). Subsequently, many may wish not to receive treatment from such therapists. Finally, Miller echoes the sentiments of Mallinckrodt and Helms (1985) and endorses the use of early disclosure on the part of counselors with visible disabilities.

Though Miller's (1991) literature review is informative and the binary division between the additive and subtractive effects makes his article comprehensible for readers, the precise partition offered here deprives the topic of its real life applicability. It is more likely that most clients may have a complicated set of reactions and feelings that may represent ambivalence and degrees of comfort. In some, to date there have not been sufficient investigation into the ways social perceptions influence the therapeutic alliance for counselors with visible disabilities. No true studies appear in the literature and the ones reported above have significant limitations.

Therapeutic alliance

The therapeutic relationship, or alliance, is a crucial factor in successful counseling (Axline, 1969; Frank, 1973; Kottler and Brown, 2000; Minuchin and Fishman, 1981; Moustakas, 1997). Rogers (1957) indicated that trust and safety in the counseling relationship were sine qua non. Power and status dynamic in the therapeutic encounter can take many forms, and different types of approaches attempt to modify the nature of power in variable ways. Client centered approaches (Rogers, 1951) for example focus on therapist of empathy and positive regard to minimize the power differential in hopes of building a relationship built upon equality. Psychoanalytic (Greenson, 1967), Structural, (Minuchin, 1974) and Strategic (Haley, 1963) therapeutic approaches, on the other hand, try to maximize the therapist's impact and make efforts to cultivate the power differential between clients and therapist. Regardless of the theory, counselors agree on the need to use therapeutic relationship to influence change.

The therapist with a visible disability is in a unique position with respect to the therapeutic alliance. For example, what does it mean for a wheelchair using counselor with Spinal Cord Injury to attain a sense of status equality with an able-body client? How might this be accomplished?

How does a counselor with quadriplegia cultivate the power differential and mobilize resources within the transference when it is clinically indicated by a particular theory? Is this process significantly different for counselors with visible disabilities than it is for able-bodied counselors? In some, how might clients' social perceptions, biases, and genuine expressions of concern for the counselor's well being influence rapport building for the counselor with a visible disability? The initial focus group that included a panel of counselors with visible disabilities was used to capture broad themes and issues related to counselors with viable disabilities. A secondary more intimate focus group was conducted in order to deeply explore the topic areas that had emerged from the initial group.

METHOD

This project is situated within the tradition of "inquiry guided" research (Mishler, 1987, 1990). Inquiry-guided research describes a "family of approaches that explicitly acknowledge and rely on the dialectic interplay of theory, method and findings over the course of the study. This includes many variants of qualitative and interpretive research that share an emphasis on the continuous process through which observations and

interpretations shape each other" (Mishler, 1990). The interpretation of events and meanings is central to this type of investigation.

This qualitative investigation was designed with the aim of bringing more face validity and candidacy to the study of counselors with visible disabilities. Considering the dearth of research on this topic, we followed the recommendations for exploratory research of (Krueger, 1994; Morgan, 1997; Stewart and Shamdasani, 1990) by utilizing the focus group to gather a wide range of social perceptions. Focus groups allowed the panel of researchers, to interact directly with the respondents and to obtain follow-up inquiries and clarifications. This synergistic effect of the group setting facilitates the production of ideas and insights that may not have been uncovered through less dynamic methods (Stewart and Shamdasani, 1990) such as simply having respondents answering a questionnaire, or individual interviewing without the opportunity for group responding.

Focus group participants ("research collaborators"), engaged in dialogue with the three panelists with visible disabilities. Participants were encouraged by the moderator to speak openly about their thoughts and resistances to sharing their thoughts. Careful attention was paid to the language used by focus group participants when describing their social perceptions associated with encountering a counselor with a visible disability. The researchers choose the forum of focus groups with the aim capturing the complexity and multiple layers of these perceptions (Polkinghorne, 2005). All of the participants in the focus groups, including the panelists, were graduate students in a counseling psychological program, except for one of the panelists who was a recent graduate of the counseling psychology program.

Initial focus group: Gathering social perceptions

The three panelists with visible disabilities consisted of a Caucasian male with Spinal Cord Injury, an Iranian female with congenital quadriplegia, and an East Indian male with visual limitation. The first author served in the role of moderator. The moderator made an effort to create a safe forum where respondents felt comfortable sharing their personal ideas on this potentially anxiety provoking topic. In addition, the moderator asked followup questions when appropriate, and attempted to explore areas of resistance and discomfort when it was expressed.

Invitations to participate in the initial focus group were sent to all Counseling Psychology Masters level students via e-mail and flyers. Fourteen graduate students ranging in age from mid 20 to early 50 s (mean age 35) attended the one-hour long group discussion. Along with the three panelists and the moderator, there were eighteen participants in the discussion. The attendees were predominantly Caucasian females.

Prior to having the open dialogue with the panelists, the attendees were asked to anonymously write down and submit their reply to the following question "What things come to mind when you think of the experience of seeing a counselor for individual therapy with a visible disability? Please write down issues that comes-up for you or you think might come-up for others."

Secondary focus group: Exploring the complexity of social perceptions

The most commonly noted comments in the first focus group were selected for a more in-depth investigation. Ten graduate students participated in the follow-up focus group. All attendees were Caucasian females ranging in age from mid 20 to early 50s (Mean = 35). The same three individuals with physical disabilities and the same discussant from the earlier event acted as moderator for the focus group.

The follow-up focus group was held two months after the first one, and participants were recruited through department-wide e-mail and posted flyers. Due to the desire for establishing a more intimate interaction, only the first ten respondents were signed in for the group. All attendees signed a consent form indicating their voluntary involvement in the focus group investigation. The focus group lasted for 75 min, covering a variety of issues relating to counselors with visible disabilities.

Three particular categories emerged from the preliminary analysis of the data from the initial focus group and

these categories were explored in more depth in the follow-up group. These included the categories of: desiring to know the nature of the disability; questioning the professional capacity of the counselor with a visible disability and desire to be forewarned about the counselor's disability prior to the first meeting.

As a way to better understand the contradictory pulls of strong curiosity about the therapist's disability and a social anxiety of offending the person through direct questioning, we asked what the counselor could do that would allow clients to feel more comfortable about inquiring about the counselor's disability. Furthermore, we inquired about the relative advantage of two inquiries "Do you have any questions about my disability?" versus "What questions can I answer for you regarding my disability?"

Through the focus group discussion, which were transcribed for later coding, the researchers attempted to understand respondents' preferences with respect to being forewarned about a counselor's disability and when during the intake process they preferred to be alerted.

Open-ended questionnaire

A conceptually clustered matrix was organized by a simple response by question format, with all responses listed in a given matrix on one axis and the question and issue posed by the facilitator and the panel on others. The use of the matrix by question format facilitated the process of thematic analysis since many of the emergent themes frequently cut across questions. For example, a matrix was created for the general conceptual category "desiring to know the nature of the disability." Responses were placed in the matrix accordingly. The anonymous comments were categorized by topic prior thematic analysis.

Following the completion of the questionnaire, a moderated discussion was held with the "research collaborators." Participants were invited to discuss issues that were reported on the questionnaires. The questionnaire proceedings were subsequently thematically analyzed. Thematic (pragmatical) content analysis, a qualitative method for analyzing data was employed to organize the written responses from the open-ended questionnaire and the transcriptions from the focus groups. Thematic content analysis focuses on the identification of salient themes and then organizes these topics by categories and sub-categories (Aronson, 1994). Careful attention was paid to understanding the full range of participants' responses. The meaning and the complexity of participant responses were analyzed through pragmatically informed content analysis.

RESULTS AND DISCUSSION

The results of the initial panel discussion were coded into 11 categories and later collapsed into 9 groups of responses. The categories are listed in Table 1 along with an exemplary response from that category.

It is noteworthy that three attendees expressed ambivalent attitudes towards a counselor with a visible disability. For instance, the same individual that stated "are they mentally fit 100%?" also noted that "i admire the courage with which they live life." Such polar attitudes may well add consistently to the complexity that exists within the therapeutic relationship between an able-body client and a counselor with a visible disability.

Furthermore, the panel revealed many of same themes that had been addressed by former studies. For instance, the notion of disability spread (Liesener and Mills, 1999) was demonstrated by the questioning the professional capacity of the counselor with a visible disability and questioning the mental capacity of the counselor with visible disability categories. The ambivalence towards those with disabilities (Miller, 1991; Mallinckrodt and Helms, 1985) was highlighted by the contradictory categories: questioning the professional capacity of the counselor with a visible disability; admiration for the counselor with a visible disability and overestimating the professional capacity of the counselor with a visible disability. Finally, the concepts of otherness and anxiety (Murdick et al., 2004) were expressed in the response categories: not knowing how to react; fear of inducing feelings of envy, discomfort, or offensiveness in the counselor with a visible disability; desire to be forewarned about the counselor's disability prior to the first meeting and questioning the humanity of the counselor with a visible disability.

Thematic content analysis of the transcript of the follow-up focus group yielded five emergent themes.

Underlying attitudes towards those with disabilities

The apprehensiveness of able-body individuals when encountering someone with a visible disability emerged as a theme. Respondents reported that they had been trained from childhood with either "don't stare" social training or they had experiences of being yelled at when trying to help a disabled person in the past. Such strong early messages can potentially have a profound impact on the therapeutic alliance between an able-body client and a physically disabled counselor, and respondents repeatedly stressed how they had be influenced by this

"early training."

Nature of the disability

Even if deep-seated taboos associated with disabilities are not an issue, respondents expressed a diverse degree of reactions to the counselor's disability depending on the condition's origin and prognoses. In this study this study, respondents indicated that they would be more curious about an acquired disability (that is spinal cord injury) rather than one present from birth. One member of the panel, a young widow, reported that she would want to know if it were a degenerative disability that may involve overtime facing the loss of the therapist.

Respondents expressed more curiosity with therapists with acquired disabilities; and it may be the case that client families may be both intrigued and have less anxiety by the therapist's story. By contrast, being confronted by someone who has faced permanent injury can awaken one's own sense of vulnerability. After meeting a counselor with an acquired physical disability the client may face. It could be me (Krieger, 1977) or my loved ones anxiety. It may be beneficial for counselors with acquired visible disabilities to be cognizant of such possibilities within their therapeutic relationships.

Table 1. Emergent categories and examples of responses.

Category	Response
1) Desire to know (not know) the nature of disability	"I would want to know. I'm more curious and would feel more comfortable if it was out in the open in the beginning, as if there was trust there already."
2) Questioning the Professional/Developmental Capacity of the Counselor with A Visible Disability	"I think it's different in a professional relationship than a personal one. I'm not entitled to personal information about the therapist. Am I?" "I would want to get it out there, like the elephant in the room. I would like to negotiate certain things, like should I help if you drop your pen?"
3) Not Knowing How To React	"I wouldn't be sure what to do….My mother taught me not to stare"
4) Questioning the Mental Capacity of the Counselor with a Visible Disability	"Are they mentally fit 100%?"
5) Fear of Inducing Feelings of Envy, Discomfort, or Offensiveness in the Counselor with A Visible Disability	"Somewhat I feel like my issues are trivial compared with what you've overcome. I might be more reluctant to talk about them."
5) Overestimating the Professional Capacity of the Counselor with A Visible Disability	"They must be really receptive to clients because they know what a disability is all about. They are more intelligent with problems/solutions because they have experienced a disability themselves."
6) Desire to be Forewarned about the Counselor's Disability Prior to the First Meeting	"It would feel presumptuous to ask questions at the beginning. I would be curious by the second or third visit, as we started to bond. I wouldn't see it as a barrier

	to the therapeutic bond. I would like the therapist to address the client's issue first."
7) Curiosity About Being Disabled	"I would be curious about what happened to him"
8) Admiration for the Counselor with A Visible Disability	"I admire the courage with which they live their life." "However, going beyond my initial response, I can also see that how success can occur after the accident…it's inspirational and hopeful."
9) Questioning the Humanity of the Counselor with A Visible Disability	"They are less of a person than I am."

Comparing one's own life to the counselor

When clients are not preoccupied with such violating social taboos or inquisitively pondering the nature of the counselor's disability, they may be assessing how their own problems may measure to those faced by their therapist. One of our participants summarized this phenolmenon by stating "somewhat I feel like my issues are trivial compared with what you've overcome. I might be more reluctant to talk about them." In such circumstances, panel members recommended that counselors with disabilities, appreciate the client's empathy, normalize themselves and the client's feelings and then comment that they may be well suited to assist with the client's problems.

In addition to minimizing their own troubles in comparison with the disabled therapist, some respondents noted that they might also develop high expectations of counselors with visible disabilities. They might look up to these therapists as extremely gift healers and expect "super cures" to them presenting their problems. The counselor faced with such a circumstance must work within the presenting transferences, and assist clients to take responsibility for their treatment and credit for their accomplishments rather than attributing them to the therapist.

Disclosure of disability

Responses to the issue of disclosure fell along a continuum. At one end were the respondents who expressed a desire to learn about the disability at the beginning of the treatment. One respondent stated that they "may be preoccupied with the encounter, rather than their issue." Another respondent noted that "this process may offer an opportunity to create rapport; to jump over the superficial." On the other end of the spectrum were those respondents who shrugged their shoulders to the question, and expressed that they did not have any interest at all in knowing about the disability in the initial meeting, and expressing that this time was for them to discuss their issues.

With respect to how should the disability be addressed; the responses were diverse with the client's state of wellbeing serving as the most important variable. "My preference would have a lot to do with my state of mind. If I was in crisis or overwhelmed, I would want my concerns to take precedence. It depends on the level of stress I'm dealing with. I need the listening person there. "If it's not a crisis? I'm comparing this to the therapist I'm seeing (in front of me), I would want some disclosure. I would prefer that the counselor come up with it, the self-disclosure of the visible disability. I would not like to have to question and probe. I would not feel comfortable asking questions, but I would want to know."

While some noted that in cases of crises, they wished that the counselor's sole attention be placed on their particular situation. In general, participants favored disclosure initiated by the counselor. The most preferential introduction to the topic was "what questions can I answer for you regarding my disability?" Participants further noted that they do not want extremely detailed descryption regarding the disability. Instead, they would prefer that the topic be left open so that they can revisit it should they have further inquires at a later date. In this regard, it may be helpful for the counselor to close the initial disclosure with comments such as "please feel free to ask me any question should they arise for you at anytime in the future. How does that sound to you?" In

addition, as one would process any emerging themes during therapy, the counselor with a visible disability has the added responsibility of remaining mindful of the role that his/her disability may play in therapy and be prepared to notice and work through any arising transference episodes as they surface.

Although there was some disagreement as to when participants wished to be informed about the counselor's disability, all participants desired to discuss the topic prior to the third session, while most wanting to know during the first meeting. Several respondents requested to know that the counselor had a disability during the initial phone contact prior to the first meeting. Further research into the timing of self disclosure for therapist with disabilities is needed.

Notwithstanding, based on both our own investigation and the findings of Mallinckrodt and Helms (1985) and Miller (1991), it is recommend that counselors with disabilities routinely practice disclosure regarding the nature of their physical condition. The self disclosure should preferably be brief and offered as early in the therapeutic relationship as possible. However, counselors must be aware of the potential that disclosure prior to the first session may deprive the counselor of face to face rapport building and result in client drop out. Given individual differences, it will be impossible to find a one size fits all formula. Future studies would be beneficial to assist in delineating some general guidelines regarding the most suitable time for disclosure.

Conclusion

The analysis of themes from the focus groups suggests that there is a broad range of preferred therapeutic approaches for counselors with visible disabilities for individuals seeking therapeutic help. Notwithstanding the wide range of respondent views, which reflect the complexity of this topic, our investigation yielded some general findings. With respect to therapist disclosure, participants generally favored brief, early disclosures initiated by the counselor. More inviting and open-ended introductions to the topic, such as, "what questions can I answer for you regarding my disability?" were preferred by most participants. Participants appreciated being told that the topic of the counselor's disability can be revisited should further inquires arise for the client at a later date. Themes from the focus groups highlighted the salience of early life messages, and revealed that clients may hold a range of deeply ingrained taboos about those with disabilities. Such social biases make the counselor's skill for carrying on open and comfortable discussions about his/her disability even more essential. By acting as a role model that contradicts the client's previous learning, the therapist may be able to offer a corrective experience that might assuage the client's anxiety towards the disabled and also enhance the client's own self disclosure throughout therapy.

When it came to the issue of acquired disabilities versus congenital conditions, clients seemed be more intrigued by the experiences of those with acquired disabilities. However, the nature of the counselor's disability might also awaken the client's fear of lose and sense of personal vulnerability. Thus, the therapist must be mindful of such concerns and recognize them in the client. Furthermore, it is not uncommon for clients to measure comparatively their current challenges with those faced by the counselor and minimize their personal concerns. Similarly, clients may develop an expectation that an individual who has overcome a personal disability may fantasize miracle cures. In such cases, in addition to understanding and working with the powerful positive transference, it might be beneficial for the therapist with a visible disability to refocus the attention back to the client, validate his/her experience, and help him/her in taking responsibility for their own treatment outcomes. Finally, counselors with visible disabilities should remain aware of the possible opposing attitudes held by clients. As we have seen, attitudes at either end of this continuum, whether positive or negative, can pose unique challenges to the therapeutic relationship. Respondents in our study reported simultaneously holding contradictory beliefs related to counselors with visible disabilities. This ambivalence thus adds to the complexity of the therapeutic relationship between able-body clients and counselors with visible disabilities and should be explored and validated as part of rapport building and the on going therapeutic process.

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