

European Journal of Counselling Psychology

Volume 1, Issue 1

August 2009

European Association of Counselling Psychology

Contents

	Page
The development and evaluation of a program to sensitize Greek Grammar School Students to issues relating to disability Sofia Triliva, Tanya Anagnostopoulou, Sofia Hatzinikolaou, Giovanni Chimienti, and Anna Mastorakou.....	3
Counselling Psychology in Medical Settings: The Promising Role of Counselling Health Psychology Evangelos C. Karademas	18
Counselling Psychology and Disability Alexandra Kanellaki and Pavlo Kanellakis	38
Editors	77

**The development and evaluation of a program to
sensitize Greek Grammar School Students to issues
relating to disability**

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* Funding was provided by the Ministry of Education of Greece

Abstract

This paper describes the design (process and content), implementation, and evaluation of a program module developed to sensitize elementary school students to issues related to disability. The objectives of the activities were to enable the students to gain factual and practical information about people with disabilities and the barriers (physical, psychological, social-emotional) they encounter. Another objective of the program was to help students and teachers examine their own attitudes toward disabilities, their stereotypes, and rejection mechanisms and stigmatization tendencies. The program evaluation outcomes suggest that students were sensitized to issues related to disability and reported more positive attitudes toward their disabled counterparts.

Keywords: counselling psychology, disability, elementary school children, attitudes

Introduction

Research efforts have shown that Greek children have superficially positive attitudes toward their deaf, blind, and physically disabled peers but are not willing to necessarily interact or share a classroom with children with disabilities (Magiati, Dockrell, & Logotheti, 2002; Nikolarazi & De Reybekiel, 2001). Moreover, the Greek educational system is structured in such a way that children who are blind, deaf or have physical disabilities have very little contact with their non-disabled peers. Greek society is changing rapidly however, and the need for valuing diversity and difference is becoming very apparent mostly through negative occurrences that proliferate in the mass media. Having worked with people with disabilities since 1978 and having witnessed the barriers that 'subtle' and 'not-so-subtle' prejudices erect, negative stereotypes perpetuate, and cultural ideologies that justify disadvantage reify we decided to develop a primary prevention community-wide intervention program that had as the goal to sensitize Greek Elementary School students in Thessaloniki to issues relating to diversity and disability.

A need for developing effective programming that would aid elementary school students in understanding, building tolerance, and empathy for their 'disabled' counterparts is well established in the literature (Maras & Brown, 2000; Nikolarazi & De Reybekiel, 2001; Shapiro & Margolis, 1988). This need is very apparent in educational settings around Greece primarily because counselling and psychological services are not readily available within the schools. In order to facilitate such an undertaking we reviewed several bodies of research literature: The literature on the development of biases, stereotypes, and prejudice (Fiske, 2004); the counselling psychology literature on understanding and promoting tolerance, compassion, difference and inclusion, in other words, social justice (Fouad, Gerstein, & Torporek, 2006; Davidson, Waldo, & Adams, 2006); and the counselling psychology literature on school-based prevention programs (Roysircar, 2006a, 2006b). From our readings we gleaned the some "wisdoms" that we used as theoretical guiding posts in the development of the intervention program.

Firstly, the social model of disability shows how disability is externally (socially constructed) and that it imposes social disadvantage, sets limits and restricts people (Reeve, 2002). Reeve's (2002) psycho-emotional model of disability involves the dimensions of disability "which affect what disabled people can be, rather than what they can do, include being hurt by the reactions of other people, being made to feel worthless and unattractive, and have their roots in the negative attitudes and prejudices about disabled people within society" (p. 495). Changing children's and broader community's ways of viewing and dealing with people with disabilities involves learning the skills to negotiate effective communication, a heightened awareness of one's own attitudes, and sensitivity to issues of stereotyping, prejudice and exclusion. Social awareness of disability embraces acknowledging an

individual's needs, special-ness, and abilities broadening of a person's models, theories, schemas, and experiences and it is through this knowledge and understanding (Carey, 1985; Shapiro & Margolis, 1988; Lewis & Lewis, 1988; Llewellyn & Hogan, 2000; Magiati et al., 2002) that each individual constructs and re-constructs their view of themselves and others. As Magiati, et al. (2002) put it: "While in no way assuming that understanding is sufficient to change attitudes and behaviour, understanding plays an important role in underpinning subsequent belief structures and patterns of behaviour" (p. 412). Hence knowledge and awareness of what disability is and what are the manifestations of disability have been found to be helping children understand their disabled peers.

On the other hand, prejudice, bias, and stereotyping involves "distancing" and the 'negation of intimacy' (Sternberg, 2005) and are counter to inclusion practices. The 'decision-commitment' involved in processes such as hate and prejudice is characterized by thoughts of devaluation and diminution through contempt for the targeted group (Sternberg, 2005). Hence, follow humans with disabilities come to be viewed in devalued ways as barely human or even as subhuman, this dehumanizing places the 'other' outside the realm of personhood and hence, 'outside the realm of social obligation' (Moshman, 2005)

The maintenance of biases and the emotions associated with negative prejudice (e.g., disdain, disgust, abhorrence, enmity, revulsion) exact a toll on the person, others around him or her and the context at large, hence the ways in which the individual influences contexts and the way that contexts influence the individual have to be taken into account when change and thriving are called for (Lerner, Bilalbegovic Balsano, Banik, & Naudeau, 2005). Lastly, the attitudes, knowledge, beliefs and behaviours of age and other social cohorts impacts upon the psychosocial functioning of children with disabilities (Gadeyne, Ghesquiere, & Onghena, 2004), overall psychosocial adjustment to disability (Parker, Schaller, & Hansmann, 2003) and acceptance of individuals with disabilities within schools and wider communities (Gilmore, Campbell, & Cuskelly, 2003).

With these empirical and theoretical findings as background, the processes, techniques, and interventions we designed and grounded the diversity program upon the following principles regarding experiential learning, change, and transformation:

1. "Diversity is enabled and fostered by communication." Communication, openness, and proactive listening lead to new ways of being together and enhance the development of respect for one another. They break down barriers and allow for firm commitment to accepting and welcoming people and ideas which are different from one's own. This form of dialogue needs take place at multiple system levels.

2. In order to “put the heart back in learning” (Postle, 1997) the teaching-learning process has to be ‘multi-modal’ (Heron, 1992). That is it has to involve multiple modes of processing-- doing, expressing (conceptualizing), imagining (learning through the use of the imagination), and emoting (learning through encounter and direct experience).
3. Children’s attitudes and understandings develop in a more positive direction when they are exposed to, come into contact with, and interact with disabled peers (Esposito & Reed, 1986; Gash & Coffery, 1995). Contact under appropriate conditions is one of the most effective and robust strategies for improving inter-group relations, largely because it helps to alleviate inter-group anxiety (Allport, 1954; Pettigrew, 1998; Pettigrew & Tropp, 2000).
4. The language of inclusion suggests that the community, not people with disabilities, needs to change; communities and community members need to become more open, welcoming, and hospitable to people with disabilities (O’Brein & O’Brein, 1996; Schwartz, 1997). At the personal level, inclusion entails the recovery of positive personal and political identity, the development of personal story and empowerment. At the relational level, inclusion means welcoming communities and supportive relationships. At the societal level, inclusion is concerned with the promotion of equity and access to valued social resources that have historically been denied to disabled people (Nelson & Prillentsky, 2005). Inclusion is fostered by a climate of connection and the legitimization of varied perspectives. Disabled people need to be given opportunities to share their unique experiences and perspectives. Moreover, legitimization of these varied perspectives counters the belief that there is one true, external reality and one single standard against which everyone should be judged.
5. Inclusion can be implemented by emphasizing similarity rather than difference, that is, by embracing and disentangling commonalities and common identifications between disabled and ‘ablebodied’ people. Inequalities in power need to be highlighted, however (Nelson & Prillentsky, 2005).
6. Context plays an integral role in health promotion and community programming in general. Context is multi-layered, schools, community, country. Freire (1970) emphasized the need for community interaction, experimentation, responsibility, and creative outputs. In order to involve the community and the broader culture and its institutions in this process of reflection, developing understandings, problematization, Consientization and praxis (Freire, 1970, 1978) the participants were: students in schools, their

teachers, university student volunteers, School Administrators and the Ministry of Education.

With these empirical and theoretical understandings in the one hand and the understandings of the mechanisms involved in the endeavour we were about to undertake, we developed a diversity program that brought primary school students and their 'disabled' counterparts into contact, promoted liberty and thriving within a community. According to Lerner (2004) this involves the development in a child's life of a sense of self wherein civic engagement and moral thought and action are synthesized. In the approach we developed this was illustrated by the actions taken by the volunteers involved, the children, and teachers in a dynamic relationship of individual and context, a context designed to promote mutuality, equity, sensitivity to individual differences, and efforts to recognize and celebrate diversity (Davidson et al., 2006). In other words the program implemented was an endeavour that emphasized Counselling Psychology's commitment to a) challenging discrimination, (b) valuing subjective experience and (c) working from a prevention and educational framework.

Curriculum Development and Permeating the School Curriculum

Developing a curriculum and a program that will encompass the themes outlined above is not an easy process. Care was taken to avoid a narrow focus upon differences and a "poor kids" (superficial sympathetic) reaction by the participants. Reflexivity and active processing of information and experience were part of each activity. In this fashion the entire program was a psychoeducational (counselling/teaching/ learning endeavour) that promoted understanding of social justice issues and an action oriented approach (Davidson et al., 2006; Toporek, Gerstein, Fouad, Roysircar, & Israel, 2006).

More specifically, the program activities were based on an experiential format where the students actively construct their experience and process what they understood/ learned through a reflective practice approach. Students took part in activities where they learned about and understood the concept of disability and their reactions to people and issues regarding disability. They were sensitized to the variety of disabilities that exist and the meaning of challenges of diversity and disability. The barriers (physical, communicational, systemic, and attitudinal) to diversity were discussed and experienced. The activities call for learning the language and etiquette of breaking down feelings of discomfort, myths, stereotypes, and misconceptions when interacting with members of the disabled community and vice-versa, that is focusing on the experiences of the 'disabled' youngsters, their anxiety, guardedness, and underlying mistrust. The activities did not seek to teach the avoidance of biases but to come face to face with them without fear. The schools', students', and volunteers' capacities to address biases and all that they entail, and to

do so with openness that is unimpeded by complicity, fear, denial, and destructive conflict is a fundamental skill in the craft of productive, happy, and just social living and it is this skill that was emphatically emphasized in all the process of the programming. The program activities along with the methods applied have recently been published in Greek in a volume titled- "Neither better nor worse, simply different" (Trivilia, Anagnostopoulou, & Hatzinikolaou, 2008).

Methods

The sample and procedure

The program was applied in two consecutive school years, 2004-2005 and 2005-2006. The first year, the program took place in 11 public schools in Thessaloniki. All in all approximately 220 primary school students, 11 teachers and 10 volunteers (including 5 people with disabilities) participated in the program. For the pre-program assessment, 219 youngsters answered the questionnaire, but only 145 of these youngsters completed the post-program assessment. The majority of the losses were due to the fact that the two 5th-grade classes (44 youngsters) were not able to sit for the post-program questionnaire. The remaining losses were due to absences. The group that sat for both pre- and post-program assessments included boys (52%) and girls (48%), and Grade 1 (35%); Grade 2 (9%); Grade 3 (25%); and Grade 6 (30%). All pre-program/post-program comparisons to evaluate program effectiveness were carried out on the data for these 145 youngsters. Other analyses were carried out on (a) the data from all youngsters who sat for the post-program evaluation (including 20 youngsters who sat for only the post-program assessment) and (b) the data from all youngsters who sat for the pre-program assessment.

In the 2005-2006 school year 203 youngsters participated in the program from grades K through 6th, 11 teachers were responsible for the applying the intervention and 7 volunteers helped with the implementation and data collection.

The intervention was applied for 10 weeks the first year and 12 weeks the second. The teachers were supervised two weeks prior and one week after the completion of the program. The intervention was applied once a week in the "health promotion" period of school work.

Measures

Evaluation is an essential component of the program implementation process. In this program we had a pre and post program phase of evaluation of the student's knowledge and attitudes regarding disability and a qualitative evaluation by the teachers.

A modified version of Hazzard's (1983) scales were used to assess children's knowledge about people with disabilities, their attitudes toward them, and their experience with people who have disabilities. The questionnaire was administered to

SENSITISATION OF STUDENTS TO ISSUES RELATING TO DISABILITY

the youngsters on two occasions: once prior to the beginning of the awareness program, and once at the end of the 12- week program.

The questionnaire consists of the following dimensions: *Knowledge*- Twenty-five true/false items were used to assess youngsters' knowledge about people with disabilities. (Example: Handicapped children usually have brothers or sisters who are not handicapped. True/False) Correct answers (as judged by professionals and by people with disabilities) included both True and False responses. A total knowledge score was obtained for each youngster by counting the number of correct responses. The knowledge score can range between 0 and 25; higher scores represent greater knowledge about people with disabilities.

Attitude. A 10-item social distance scale was used to assess youngsters' attitudes toward people with disabilities. Using 10 examples of social interactions, the scale measures the level of closeness with disabled people that the youngster finds acceptable. (Example: It would bother me if a handicapped youngster sat next to me in class.) Responses were given the following point values: Yes = 0; Maybe = 1; No = 2. An attitude (social distance) score was obtained for each youngster by adding up the points on the 10 items. The attitude score can range from 0 to 20. Higher scores indicate more positive attitudes toward children with disabilities (i.e., less social distance).

Experience. Seven items were used to assess the extent of youngsters' exposure to or experience with people who are disabled. Each youngster was given a score that reflected the highest level of his/her contact with disabled people, as follows: 0 = no exposure/experience; 1 = only medium exposure; 2 = on the streets or in shops (low level of direct contact); 3 = friend or family member who is disabled (high level of direct contact). Higher scores thus reflect more direct experience.

Results

Table 1 shows youngsters' average pre-program and post-program scores on knowledge, attitude, and experience. Youngsters showed significant increases on all three measures following the disability awareness program. *Knowledge*: Following the disability awareness program, youngsters had more correct information about disabled people and their capabilities. *Attitude*: Following the awareness program, youngsters reported more positive attitudes toward disabled children, indicating that they would accept closer contacts with them. *Experience*: Following the awareness program, youngsters reported higher levels of exposure/contact. The post-program increases in knowledge, attitude and experience scores were, in general, similar for boys and girls, and for children at all grade levels in the sample (1, 2, 4, and 6).

Further analysis of the post-program data provided additional interesting information. Table 2 shows the average knowledge, attitude and experience scores for boys and for girls. There were no significant differences between boys' and girls'

SENSITISATION OF STUDENTS TO ISSUES RELATING TO DISABILITY

Table 1
Average Pre-Program and Post-Program Scores on Knowledge, Attitude, and Experience

	Pre-Program	Post-Program	t-test results
Knowledge	10.2	13.2	t(df = 144) = 8.97, p < .001
Attitude	14.7	17.2	t(df = 144) = 5.79, p < .001
Experience	2.1	2.3	t(df = 144) = 2.60, p < .01

scores on knowledge about the disabled, attitude toward the disabled, or experience with the disabled.

Table 3 shows the average knowledge, attitude and experience scores for youngsters in school grades 1, 2, 3, and 6. *Knowledge*: Knowledge scores increased significantly with grade level. *Attitude*: Attitude scores varied significantly for the different grade levels, but there was no clear pattern related to school grade. *Experience*: Experience scores varied significantly with grade level. The pattern suggests that children in the higher grades have had more experience/contact with the disabled.

Correlation coefficients are shown in Table 4. There was a significant positive correlation between knowledge scores and attitude scores. Those youngsters with more knowledge about people with disabilities tended to have more positive attitudes toward them. Attitudes toward the disabled were significantly positively related to experience with the disabled. Those youngsters with greater experience of the disabled tended to have more positive attitudes toward them. Table 5 gives the average knowledge scores for youngsters with different levels of contact/experience with the disabled. The table shows that, in general, those youngsters with more direct experience with the disabled tend to have more knowledge about the disabled.

Table 2
Average Knowledge, Attitude and Experience Scores for Boys and Girls

(The table includes the responses of 20 youngsters who were absent at the time of the pre-program questionnaire.)

	Boys (n = 85)	Girls (n = 80)
Knowledge	13.3	13.3
Attitude	17.5	17.0
Experience	2.4	2.3

SENSITISATION OF STUDENTS TO ISSUES RELATING TO DISABILITY

Table 3

Average Knowledge, Attitude and Experience Scores for Youngsters in Grades 1, 2, 3 and 6

(The table includes the responses of 20 youngsters who were absent at the time of the pre-program questionnaire.)

	Grade 1 (n = 55)	Grade 2 (n = 17)	Grade 3 (n = 42)	Grade 6 (n = 51)
Knowledge	12.0	12.9	13.2	15.0
Attitude	15.9	18.6	18.8	17.0
Experience	2.5	2.1	2.2	2.3

Table 4

Correlation Coefficients for Knowledge, Attitude, and Experience Scores

(includes the data of all youngsters who sat for the pre-program questionnaire, n = 219)

Variables	Pearson Correlation	Significance
Knowledge – Attitude	$r_{xy} = .21$	$p < .01$
Experience – Attitude	$r_{xy} = .14$	$p < .05$
Knowledge – Experience	$r_{xy} = .16$	$p < .03$

Table 5

Average Knowledge Scores for Youngsters with Different Levels of Experience with the Disabled

(The table includes the responses of 20 youngsters who were absent at the time of the pre-program questionnaire.)

	No experience (n = 4)	Medium experience (n = 8)	Low direct experience (n = 85)	High direct experience (n = 68)
Knowledge Score	10.5	12.1	13.8	13.0

Table 6

Average pre-program and post-program scores on knowledge, attitude, and experience

	Pre-program	Post-program	t-test results
Knowledge	10.84	14.33	$t(98) = 6.20, p < .00$
Attitude	15.65	16.78	$t(142) = 2.61, p < .01$
Experience	2.82	3.46	$t(138) = 4.58, p < .00$

SENSITISATION OF STUDENTS TO ISSUES RELATING TO DISABILITY

During the second application, more robust results were tabulated and Table 6 displays the pre-and post-program scores on knowledge, attitude and experience with issues related to disability for youngsters in all the grades (K through 6th).

Youngsters showed significant increases on all three measures following the disability awareness program. *Knowledge*: Following the disability awareness program, youngsters had more correct information about disabled people and their capabilities. *Attitude*: Following the awareness program, youngsters reported more positive attitudes toward disabled children, indicating that they would accept closer contacts with them. *Experience*: Following the awareness program, youngsters reported higher levels of exposure/contact. The post-program increases in knowledge, attitude and experience scores were, in general, similar for boys and girls, and for children at all grade levels in the sample (0, 1, 2, 3, 4, 5 and 6). Sex had no effect on pre- program and post program scores on knowledge, attitude and experience.

Qualitative evaluation

The teachers were asked to evaluate their experience in implementing the program in their classrooms. From their written accounts of the program the following themes emerged:

1. Learning to challenge own biases, stereotypes and fears
2. Coming in contact with children with disabilities was the most successful component of the program with the students
3. The fact that 'taboo' issues were discussed was enough to bring about change
4. The students were given the chance to go beyond books and school subjects and to touch upon social issues that they confront every day.

The educators also outlined the draw-backs of the program pointing out the limited time in implementing the program (12-weeks and only one hour per week). They also recommend more contact with children with disabilities and the chance to collaborate with 'special schools' and children with disabilities on various school projects.

Discussion

Following the disability awareness program, youngsters showed significant increases on all three measures: They had more correct information about disabled people and their capabilities; they reported more positive attitudes toward disabled children; and they reported higher levels of exposure to/contact with disabled people. These post-program increases in knowledge, attitude and experience scores were, in general, similar for boys and girls, and for all grade levels in the sample (1,

2, 4, and 6). These results point to the relative success of the disability awareness program activities. They also highlight the need for continuing efforts at increasing knowledge, strengthening positive attitudes, and increasing youngsters' direct experience with the disabled, as shown by the following observations.

Knowledge. The average post-program knowledge score from the two years was 14.33. That is, the youngsters taking part in the awareness program, on average, got only 14 out of 25 knowledge questions correct. About 50% of the youngsters had scores below 14, and about 15% of them had scores below 10 (out of 25) on the knowledge scale. Clearly there is room for improvement in the area of youngsters' factual knowledge about people with disabilities.

Attitude. The average post-program attitude score from the two years of implementation was 17.3. With 20 indicating the maximum positive attitude on this scale, an average of 17 looks good. But it should be noted that about half of the youngsters obtained scores below 17, and about 15% obtained scores below 13.5. Since a score of 10 indicates (roughly) a 'neutral' position on interacting with disabled children, there is clearly a need to strengthen positive attitudes toward people with disabilities.

Experience. The average post-program experience score was 3.30. About 7% of youngsters had had no experience or only medium exposure to children with disabilities, and these youngsters are in need of more exposure to people with disabilities.

Based on the 423 youngsters who answered the pre-program questionnaire, it was found that:

- Knowledge scores were positively related to attitude scores: Youngsters with more knowledge about the disabled tended to have more positive attitudes toward them.
- Experience scores were positively related to attitude scores: Youngsters with more direct experience/contact with the disabled tended to have more positive attitudes toward them.

These relationships support the idea that the disability awareness program was able to strengthen positive attitudes toward the disabled (a) by providing the participants with more information about the disabled and their capabilities and (b) by increasing the youngsters' experience/contact with people who are disabled. This program involved the supervision of the teachers and their sensitization to both the experiential methodology but also the issues of their own biases, stereotypical thinking and attitudes towards people with disability and this proved to be important components of program design.

The way ahead

Now is the time to change. The importance of difference is gaining acceptance. Times are changing in Greece with regard to segregated placements for disabled students. Recent legislation and changing social values are beginning to reverse the trend toward segregation, exclusion and bias, yet students feel ignorant about and uncomfortable around disabled persons (Magiati et al., 2002). There is evidence from this study to suggest that the psychoeducational (counselling and education within an experiential format) activities did enable the learning objectives to be met in a measurable way. There is evidence from the teacher's evaluations that the program enables the sensitization and awareness about disability. With regard to attitude and behaviour change of the students the program needs to be extended for the entire school year, there need to be more activities and perhaps it needs to include all forms of diversity as well as a more action oriented community component.

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SENSITISATION OF STUDENTS TO ISSUES RELATING TO DISABILITY

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SENSITISATION OF STUDENTS TO ISSUES RELATING TO DISABILITY

Trivilia, S., Anagnostopoulou, T., & Hatzinikolaou, S. (2008). *Oute kalyteros, oute chiroteros, alpha diaforetikos [Neither better, nor worse, simply different]*. Athens: Gutenberg.

Counselling Psychology in Medical Settings: The Promising Role of Counselling Health Psychology

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Abstract

In recent decades a biopsychosocial understanding of health predominated, and health problems stopped being just a physician's job. Consequently, the role of experienced psychologists in health care is gradually becoming more important. Counselling Psychology as a major field of psychological science with an enormous knowledge and experience in dealing with a diversity of problems has only to offer to the medical health care. Our purpose is to present the multiple roles of counselling psychologists (e.g., as evaluators, advisors, therapists) in health and health care. Issues regarding the training of 'health counselling psychologists' are also being discussed. Finally, I argue about the opportunities and difficulties that counselling health psychologists may meet in daily practice.

Keywords: counselling health psychology; medical health care; health care provision.

During the second half of the 20th century the field of human health and health care was faced with significant changes and new challenges. Gentry (1984) highlighted several aspects of this new environment in health and health care, such as the failure of the biomedical model to fully explain health and illness, the shift to chronic diseases as the main health problem, the realization of the role of psychological and life-style factors in the manifestation and maintenance of health problems, the development of sophisticated psychological theories about health. These factors facilitated the formation of relatively new initiatives within the field of psychological science, while new specialties and professional categories emerged. During the '70s and '80s certain major national and international associations were established with the aim to promote 'behavioural medicine' or 'health psychology', whereas new relevant scientific journals were published (for a more detailed review, Belar & Deardorff, 1995; Kaptein & Weinman, 2004). As a result, in the following decades a new understanding of health and illness appeared, psychological research

on health and health related factors increased, and health problems, especially chronic diseases, stopped being just a physician's job. Patients were increasingly referred to psychologists for treatment and symptom management, while psychologists were involved in the efforts for health maintenance and health promotion in almost every population (e.g., Ayers et al., 2007; Bennett, 2000; Sarafino, 1999). Thus, the role of health, clinical and counselling psychologists in health care gradually became more important.

The purpose of the present article is to briefly present the multiple roles of counselling psychologists in health and health care, discuss relevant training demands, argue about ethical issues, as well as about the opportunities and difficulties of working in medical settings. Of course the whole issue is vast. Therefore, the present document intends to be only a brief discussion of issues related to counselling health psychology.

Counselling Psychology and health care

In 1982, Millon defined health psychology as "the application of knowledge and methods from all substantial fields of psychology to the promotion and maintenance of mental and physical health of the individual and the prevention, assessment and treatment of all forms of mental and physical disorder in which psychological influences either contribute to or can be used to relieve an individual's distress and dysfunction" (p. 9). Counselling psychology as a major field of psychological science with an enormous knowledge and experience in treating a diversity of problems has only to offer to medical health care. As a developmentally based specialty that emphasizes building on person's strengths, treating persons with respect and care, taking into consideration and incorporating environmental factors and resources, using psycho-education in treatment, employing the biopsychosocial model for understanding health and managing health problems, and being familiar with interdisciplinary collaboration, counselling psychology can significantly contribute in health-related applications (Altmaier & Johnson, 1992; Roth-Roemer, Robinson Kurpius, & Carmin, 1998).

Counselling psychology was directly related to health care for the first time in 1979, when Krumboltz, Becker-Haven and Burnett published an article on counselling psychology in the *Annual Review of Psychology*, and discussed treatments for certain health problems, including pain and insomnia. Following that, a relevant chapter in the first edition of the *Handbook of Counselling Psychology* was published by Thoresen and Eangleston (1984), while the same authors published next year a similar article in *The Counselling Psychologist* (Thoresen & Eangleston, 1985). In 1998, a first edition exclusively dedicated to the role of Counselling Psychology in health care was published (Roth-Roemer et al., 1998). This edition focused on a variety of topics, like professional issues, areas of practice, and interventions in special populations. Since then, several efforts to promote

counselling psychology in health care have been developed. For instance, within the Society of Counselling Psychology of the American Psychological Association (Division 17) a section of Counselling Health Psychology has been established. This section is dedicated to the science and practice of counselling psychology in health-related contexts through research, intervention, training of young students or professionals, and development of health policy initiatives (for more information, http://www.div17.org/sections_chp.html). Also, the Division of Counselling Psychology of the British Psychological Society acknowledges the breadth of places that a counselling psychologist may work, including medical settings (for more information, <http://www.bps.org.uk/dcop/>). Indeed, the role of counselling psychologists in such settings is fast growing.

The role of counselling psychologists in medical settings

As experts in human behaviour, counselling psychologists can assume a diversity of roles within health care services. They may evaluate and assess the psychological functioning of the patients; act as advisors for the treatment team; provide training; organize and implement research projects; provide counselling or other types of psychosocial interventions to the patients and their families.

- a) Carmin and Roth-Roemer (1998) underlined that psychologists are frequently asked to perform a psychological assessment of medical patients. They are asked to evaluate whether patients suffer from problems that might interfere with or complicate medical assessment and treatment (such as cognitive deficits, anxiety or mood disorders), or to differentiate between a medical and a physical condition. In fact, Rief (2004) reported that about 20% of the visits to a physician involve symptoms that cannot be explained by a typical medical disorder, while Ansseau et al. (2004) in a sample of 2316 adult patients found that 42.5% of them are met with some type of psychological difficulty, mainly emotional, anxiety and somatoform symptoms. Furthermore, there is a significant problem of under-diagnosing psychological difficulties in typical health care services, like hospitals or medical centers. Kunen, Smith, Niederhauser, Morris and Marx (2005) reported that under-diagnosis reaches almost 75% of all relevant cases. Moreover, mental health problems constitute a major financial burden to the health system and the national economy (Layard, 2005).

Medical staff is rarely ready to identify and, of course, address psychological difficulties (Layard, 2005). Therefore, the role of the psychologist in assessing and addressing psychosocial problems, as well as in alleviating the frustration that medical personnel often feels when dealing with such problems, is crucial and in favour of both patients and staff.

The assessment of psychosocial functioning usually relies on the classical clinical interview and use of diagnostic instruments, some of which are especially designed for use within medical settings (for a review, Bennett, 2000; Belar & Deardorff, 1995). In the assessment process not only the patients might be involved, but also family and relatives, or even the medical personnel. However, assessment and diagnosis in a medical setting is subject to limitations, such as the lack of a private place for the interview to take place, lack of time, need for quick answers, medication side-effects etc. Consequently, psychologists are often called to improvise in order to effectively adapt and perform under these conditions (for a review and related suggestions, Van Egeren, 2004).

- b) Counselling psychologists are especially trained in consultation. This is critical whenever they have to act as advisors or consultants to the treatment team of a patient. This part of the counselling psychologists' role is important as they can provide information regarding the psychological well-being of the patients (BPS Division of Counselling Psychology, 2007; Kagan et al., 1988), but also offer specific recommendations that will assist medical staff. Moreover, counselling psychologists can provide medical staff with pieces of advice or instructions on how to manage everyday difficulties (e.g., workload, difficulties in decision making, dealing with death and dying patients) (BPS Division of Counselling Psychology, 2007; Earll & Bath, 2004). In their efforts, counselling health psychologists have to consider information regarding all major parts of the medical milieu: patients and their needs, medical personnel, the environment, and any special conditions (Carmin & Roth-Roemer, 1998). It is a rather difficult task and, therefore, psychologists should be familiar with a diversity of factors both psychological and medical.
- c) Additionally to their role as advisors or consultants, counselling psychologists are frequently called upon to train physicians or nurses in counselling related issues, such as effective communication, patient-medical staff relationships, stress management, psychological factors associated with health and illness and so on (Kagan et al., 1988). They can also teach specific techniques for dealing with problems like pain or insomnia, or specific ways for managing personal and professional difficulties, like burnout or troubled communication (Walker, 2004). Training can also be addressed to the patients as a component of an intervention program.
- d) A most crucial aspect of the counselling psychologist's role within a health setting is to provide counselling or other types of intervention to those in need. According to Bennett (2000), and Belar and Deardorff (1995), a psychologist can offer substantial help at every level of the patient's

functioning: physical level (e.g., pain and other symptoms management, reduction in psychophysiological arousal), emotional level (e.g., stress management, dealing with symptoms of depression and anxiety), cognitive (e.g., provide information, help in changing dysfunctional thoughts), and behavioural (e.g., modification of maladaptive behaviours, increase adherence to medical therapy). Furthermore, counselling psychologists can offer help to the families of the patients (e.g., by means of providing information, support, training etc.), as well as to the medical personnel for dealing with special conditions, or to the broader socio-cultural milieu (e.g., by mobilizing a social support system, organizing and implementing prevention efforts etc).

In fact, the range of possible intervention targets for the patients is quite wide: from preparing patients for difficult operation procedures, to training them to effectively cope with the post-surgery problems or with medical treatment side-effects; from helping them to change unhealthy behaviours (including weight control and smoking cessation) to providing counselling for dealing with emotional and adjustment difficulties; and from breaking bad news to helping the dying (Karademas, 2005).

In order to achieve their intervention goals, counselling health psychologists may choose from an array of intervention strategies and techniques: individual and group counselling, brief therapies, providing information and training, crisis intervention, stress management, motivational interview, guided imagery, behaviour analysis and modification, cognitive restructuring and many more. The majority of these techniques and strategies are based on the cognitive-behavioural model, which has been found really effective in treating many health conditions, including: cardiovascular disorders (e.g., Bellg, 2004; Gidron, Davidson, & Bata, 1999); neoplasms (e.g., Khazam, 1996; Spira & Reed, 2002); diabetes mellitus (e.g., Norris, Engelgau, & Narayan, 2001); HIV/ AIDS (e.g., Bor, du Plessis, & Russell, 2004; Bor & du Plessis, 1997; Chesney & Antoni, 2002); sexual health (e.g., Aarø et al., 2006); surgical procedures (e.g., Lang et al., 2000; Petry, 2000); renal disease (e.g., Griva & Newman, 2007); urological disorders (e.g., Nicolau, Toro, & Perez Prado, 1991); dermatology (e.g., Kent & Keohane, 2001; Papadopoulos, Walker, Aitken, & Bor, 2000); obstetrics (e.g., Klock, 2004); transplantation (e.g., Blumenthal et al., 2006) etc. Medical patients are rather interested in short-term and focused interventions that can facilitate their recovery, than long-term insight-oriented therapies (Carmin & Roth-Roemer, 1998). These requirements are typically met by behavioural (e.g., conditioning, operant conditioning, modeling), cognitive (e.g., self-management, cognitive therapy), and cognitive-behavioural approaches (for more details, Bennett, 2000; Bennett, Conner, & Godin, 2004; Lorig, 1996;

Rutter & Quine, 2002). An interesting tool, which provides guidelines for the development of intervention programmes, for the application of theory, as well as for the transformation of theory into practice and the selection of appropriate methods and strategies, is the Intervention Mapping (see, Kok & Schaalma, 2004). Intervention Mapping may be really useful for practitioners, especially at the beginning of their career.

In any case, psychologists must be cautious when selecting a strategy, as they have to take into consideration issues like the effectiveness of each strategy, possible interference with the physical functioning and possible side-effects of the medical treatment, the cost/ effectiveness ratio, time limits and so on. Counselling health psychologists should also follow all necessary steps to secure an evidence-based practice, which is the best way to promote patients' well-being (Spring, 2007; Walker & London, 2007).

Additionally, in recent years, the intervention role of counselling psychologists is expanding to new fields, including genetic testing and related counselling services (Wang, Gonzalez, & Merajver, 2004), telehealth counselling services (Miller, 2006), and spiritual issues and health (Thoresen, 1999). As our understanding of the role of psychosocial and behavioural factors in health deepens, more and more efficient intervention programs are developed in favour of the patients and the health care system. The implementation of these programs, however, requires for highly trained and capable experts, an issue that I will refer to later on.

- e) Finally, counselling health psychologists may plan and implement research activities. Psychological factors related to health and illness, adaptation to illness, well-being and quality of life and many more, are the issues that counselling health psychologists can study in order to gain a better understanding of health and illness and achieve a better practice. A significant field of research might also be the empirical testing and evaluation of the several intervention strategies. In these efforts, psychologists should collaborate with the medical personnel and include in their studies medical and biological variables as well (Suls & Rothman, 2004).

Gatchel and Oordt (2003) underlined the fact that the approaches for providing psychological services fall on a continuum, depending on the characteristics of each health service. According to the authors, within this continuous lie four major models. These models were described in relation to primary health care, but I think we can easily adopt them in relation to any health care setting. In the "collocated clinics" model, the psychologist is usually with a traditional psychological clinic and not integrated into the health care clinic. Actually, medical and psychological (or psychiatric) clinics remain two different entities. In the second model, the psychologist may act as a provider within the medical clinic. Accordingly, he/she

may provide counselling or therapy for both mental health and medical conditions. The psychologist collaborates with the medical personnel, although he/she is still an 'independent provider' of health care. This model resembles the first one, but in this case the psychological work is offered as part of the same clinic. In the third model, the psychologist acts as a "behavioural health consultant". She/he is a member of a multidisciplinary team and responsible for the behavioural and psychological aspects of treatment. The psychologist evaluates the patient and makes recommendations to the case manager (the physician). She/he may see the patient for a limited number of sessions (one or two) to monitor the implementation of the recommendations or provide specific advice. In parallel, the psychologist can provide targeted services to specific groups of patients (e.g., stress management to heart attack patients). In case of more intense problems the psychologist may refer the patient to other specialized psychological services. The final model refers to the psychologist as the "staff adviser", who consults only the medical staff. She/he has no independent contact with the patients, but rather uses her or his expertise to assist the medical staff with defining and treating the problem.

Each of the models presented by Gatchel and Oordt (2003) has advantages and disadvantages and may be appropriate for one setting, but not for another. It lies with the setting and the scientific staff to decide upon which model better fits their needs. Of course, the models presented are not mutually exclusive (Gatchel & Oordt, 2003). A combination of these might be the most efficient and proper solution. Likewise, Pruitt, Klapow, Epping-Jordon and Dresselhaus (1998) proposed a stepped-care approach: the psychologist initially provides advice to the medical staff in order to deal with a patient. Should no improvement occurs, the psychologist may be engaged in a personal contact with the patient in order to make a more thorough assessment and provide the appropriate treatment. If also no improvement is achieved, then the psychologist may decide to provide a more extensive therapy or refer the patient to another service.

I believe that counselling psychologists working within a medical setting should (a) originally evaluate current conditions in the setting, (b) assess the needs of the typical patients of that setting, as well as (c) of the medical personnel, (d) collaborate with the other members of the scientific staff, and then (e) determine and finally adopt the most appropriate model that will permit them to perform the necessary diagnostic, intervention, consulting, training and research work.

At this point, I should emphasize the fact that especially in United Kingdom a fast growing number of counsellors work in primary care and general practice. As Foster (2000) reports, from almost no primary care counselling provision in 1980, there were counsellors in 51% of the surgeries in England and Wales at the time "the new National Health System" was launched. This expansion of counselling services was rapid but, according to many, haphazard and fragmentary (Eatock, 2000; Mello-Clark, 2000). Still, the numbers of counsellors and counselling psychologists in

general practice are growing and the National Health System is probably the major employer of counsellors in UK (Eatock, 2000). However, their work is primarily focused on mental health issues. Although mental health is of great importance for all medical patients and their survival and quality of life, working as a mental health professional is different than serving as a 'counselling health psychologist'. For instance, a mental health professional focuses on psychosocial issues and their association with health. On the other hand, a 'counselling health psychologist' focuses not only to mental health issues, but also on many more topics related to physical health (e.g., adherence, physical symptoms management, life-style etc), even when no mental health difficulty is present. It is my opinion that counselling psychologists working within primary care in UK could also assume the role of a 'counselling health psychologist' with success and expand their responsibilities within the health care system. After all, there is evidence suggesting that their services are effective and the help they offer substantial (Baker, Allen, Gibson, Newth, & Baker, 1998; Bower, Rowland, & Hardy, 2003), while their contribution to the development of primary care is more than significant (e.g., Lenihan & Iliffe, 2000).

Ethical issues

Beside competence, which is an always challenging aspect of practice, there is an array of ethical issues related to the practice in a medical setting. Indeed, counselling psychologists are sensitive to issues associated with the psychologist's responsibilities and the patient's rights (Robinson Kurpius & Vaughn Fielder, 1998). However, protecting rights within a health care service could be challenging at times, especially regarding confidentiality and the proper use of psychological information (Hudson-Allez, 2000). Sometimes it is difficult to uphold confidentiality in a medical setting, due to three major factors: the psychologist usually has to share information with the other members of the multidisciplinary team (e.g., physicians and nurses) or keep notes in the patient's medical record (if there are no separate psychological records); the psychologist might not be able to see the patient privately, but in multibed rooms; the psychologist often needs to inform the patient's family, since collaboration with family members is frequently critical for the treatment (Bennett, 2000; Belar & Deardorff, 1995; Hudson-Allez, 2000).

In order to deal with these challenges, the counselling health psychologist must enrol brains and talent. She/he must also be sure that patients understand the procedures of sharing information with medical personnel or keeping informed the hospital record. He/she has to obtain consent to provide confidential information, unless the patient is unable to make informed decisions (Bennett, 2000; Papas, Belar, & Rozensky, 2004). Of course, patients should always be given the option of declining psychological services, after a discussion on its purposes, aims, and restrictions.

Opportunities and difficulties of working in medical settings

Despite the opportunities that health care provides, and the significant contribution that counselling psychology can make, only a relatively small number of counselling psychologists seem to work in such services, while not many programs provide systematic training for such a possibility. In fact, until early '90s only a small percentage of counselling psychologists were working in the health domain (Good, 1992), despite the growing employment opportunities (see for example, http://www.health-psychology.org.uk/menuItems/what_is_health_psychology.php).

Altmaier in 1984 reported that almost 60% of the counselling psychology training programs in the USA had no health psychology course work, whereas more than half reported practicum placements in health psychology. Furthermore, students reported a moderate interest in the area. More recently, however, the interest in health psychology practice appears to be increased, but not much. Neimeyer, Bowman and Stewart (2001) reported data from 1989 to 1998 indicating that about 17% of graduates of counselling psychology programs in the US have been employed in hospitals, whereas more than 80% were still placed in counselling and mental health centres, in private practice, and in academia. In the same line, Stedman, Hatch, Keilin, & Schoenfeld (2005) in their description of internship training of clinical and counselling psychologists concluded that training still focus heavily on the traditional clinical-provider role, while there is little evidence of innovation towards new areas of research and practice (like health settings). In the United Kingdom, only 4% of the applied psychologists work with clients suffering from physical health problems, according to recent surveys (BPS, 2007). On the other hand, about 40% of the chartered counselling psychologists in England are employed at the National Health System (BPS, 2005). Obviously, they work with mental health-related problems. It is possible that the disadvantages of working in a physical health care setting (i.e., coming to terms with the medical hierarchy, maintaining confidentiality, as well as the difficulties in communicating with the medical personnel (Good, 1992) are keeping young counselling psychologists from practicing their profession in such settings, despite the existing advantages (e.g., the diversity of the roles a counselling psychologist could assume). Moreover, the traditional focus of counselling psychology and relevant training programs on the more typical mental difficulties and psychosocial troubles, which usually does not include chronic diseases and physical health, might be another significant reason for this trend.

Indeed, working within a medical setting might be really demanding and complex. I will use the primary care services as an example. Primary care is defined as the very first care provided to the patients when they enter the health care system (Bray, 1996). As Gatchel and Oordt (2003) pointed out, psychologists working in such settings usually have to give up some level of their autonomy. At the same time, they have to see the entire population served by the clinic. As a result, they need to develop specific skills for focused and quick assessments, provide brief practical

advice, do their job in very short times, make decisions with limited amount of data, develop skills for enhancing motivation to change, use brief interventions, communicate efficiently with the medical staff (i.e., avoid jargon, be brief and focused), tolerate a rather low position in the hierarchy (physicians are usually the 'chief'), be flexible in their hours and available to patients and medical staff whenever there is need. Psychologists in primary care might also have to be quite 'creative' in their practice in order to be more effective (e.g., use telephone or web conferences, use the phone or even the fax to provide advice, advise the other members of the team in 'unusual' opportunities, e.g., during lunch). Furthermore, counselling psychologists sometimes have to work hard to spotlight their identity and their skills, since there is still considerable confusion and lack of information regarding their role in care provision (e.g., Lewis & Bor, 1998). All these can be quite burdensome to the psychologists and significantly tax their abilities to adapt. Consequently, they often avoid primary care settings.

On the other hand, medical settings may provide opportunities for the counselling psychologists to display their unique knowledge and skills, as in the case of cross-cultural health care. The ways a person perceives symptoms, reacts to illness, thinks about health and behaves are rooted in her/his culture and culture-related belief system (Pedersen, 1997). A growing literature describes the strong associations between differences in culture, and health, well-being, health related beliefs and behaviours (e.g., Arrendondo et al., 1996; Marks, Murray, Evans, & Willig, 2000; Salant & Lauderdale, 2003), while there is evidence that cultural differences are associated with perceptions about the cause or the appropriate treatment of a disease (e.g., Karasz, 2005). Culture is so important for health and illness that many diseases seem to be 'caused' by local cultural habits (e.g., Boirin, 1997; Schensul, Mekki-Berrada, Nastasi, Saggurti, & Varma, 2006). Nevertheless, a major problem in the medical setting is the difficulty of the medical personnel to take into consideration the role of culture or cross-cultural variables (Atkinson, 2002; Prislín, Suarez, Simpson, & Dyer, 1998). Therefore, it lies with the psychologists to help medical personnel realize the significance of culture and cultural differences, and also promote 'cultural sensitive' or 'cultural focused' intervention programs (Pedersen, 1997), in order to facilitate patients' adaptation and enhance well-being and health.

Even with these opportunities, there is still a possibility that some counselling psychologists worry about counselling psychology losing its identity (Tyler, 1980). For example, Bernard (1992) and Good (1992) are afraid that counselling psychologists working in medical settings will alienate from their colleagues. On the contrary, Altmaier, Johnson and Paulsen (1998) support that no alienation will occur and counselling psychologists will keep their identity. In the same line, Mrdjenovich and Moore (2004) believe that counselling health psychology will maintain ties with the substantial area of counselling psychology and will not turn to be a 'subspecialty' of health psychology. These authors define professional identity as the sense of

connection to the values and emphases of counselling psychology. If counselling psychologists retain this sense of connection, then they will preserve their identity and will be able to make a unique contribution to the field of medical care. I concur with their opinion and, as Hudson-Allez (2000) suggests, I also believe that a counselling psychologist, irrelevant of his/her working environment, should always be an experienced practitioner with a solid counselling or psychotherapeutic training. Such training combined with a constant integration of new counselling/psychotherapeutic knowledge and techniques, and a continuous focus on the patient as a 'person' differentiates counselling psychologists from other psychology specialists and help them keep their identity. And by keeping their identity, they can effectively collaborate with medical staff and other specializations in psychology (such as health psychologists) in favour of the patients and in order to deal with the multiplicity and the complexity of their needs. After all, as Walsh, Frankland, and Cross (2004) underline, "*counselling psychologists also endeavour to modify the medical model system of relating from within the medical world, without compromising our [counselling psychologists'] or their standards and ethos*" (p. 326).

Training counselling psychologists for the medical settings

Training in counselling psychology is insufficient for practice in a medical setting. Moreover, with the exception of rehabilitation counselling, post-graduate and doctoral programs in counselling psychology are very slow or even reluctant to add health-related courses and practice (Alcorn, 1998; Stedman et al., 2005). In this section I will discuss certain aspects of training in counselling health psychology in brief. For a more extensive description of the educational and training demands linked to counselling health psychology I refer to Alcorn (1998), Michie, Abraham and Johnston (2004), Papas et al. (2004), as well as to the BPS Board of Examiners in Health Psychology (2001).

Although, counselling psychologists are traditionally trained in those areas that are commonly used within the field of health care, including psycho-education, human relationships, and behaviour modification, they should also be trained in a "health psychology" philosophy, as well as in specific skills. According to the American Psychological Association Council of Representatives (1997), for instance, psychologists working in medical health settings should be familiar with and have a broad understanding of several issues and quite a lot areas of knowledge, such as: biological, cognitive, affective and social bases of health, disease and behaviour; anatomy and human physiology; health behaviours and related factors; illness and disability effects on cognition, emotion and behaviour; the role of a diversity of factors, such as culture, patient-doctor relationships, health policy, stress etc. In the same line, in United Kingdom health psychologists need to be able to develop theory and conduct research, assess and intervene in order to improve health care and health outcomes even in complex situations, use ethical awareness to develop best

practice, train other health professionals, as well as consult health care personnel and managers (Michie et al., 2004).

Alcorn (1998) proposed an integration of certain courses with the core curriculum in counselling psychology. These courses are: introduction to health psychology, medical aspects of disability, psychopharmacology, medical terminology, neuropsychology, and community health. He also stressed the importance of the integration of science and practice (which, nevertheless, is common ground among counselling psychologists), as well as the necessity for training in the multidisciplinary nature of the work in medical health settings.

Equally, if not more, important are the internship experiences in medical settings and hospitals for the counselling psychologists interested in health psychology. Well-designed internships in different medical clinics, rehabilitation centres, pain clinics, medical schools or similar settings, under the supervision of experts, are essential for a good practice. Internships should be designed in a way to help young trainees adapt their knowledge and skills in the health setting, as well as prepare them to deal with a variety of difficulties and problems. It should also be noted that internship in specific settings (e.g., pain clinics) is a possible pathway through which professional specialization can be achieved.

The specific form that training in counselling health psychology should take depends on many factors: the educational system of each country, the form of the health care system, history, needs, and special conditions. For instance, in the USA to qualify for board certification in clinical health psychology, a doctoral degree in psychology (e.g., in Counselling Health Psychology) is needed, among other requirements regarding training, internship, continuing education and current professional work (ABPP, 1999). Counselling psychologists seem to applaud the development of health psychology as a post-doctoral specialty field (Alcorn, 1998). Likewise, a post-doctoral training in health psychology-related issues might be a solution for British counselling psychologists. (It should be noticed here that also the European Association for Counselling Psychology (EACP) accepts as full members only those counselling psychologists who are qualified at a doctoral level (see the Statutes of the EACP, <http://www.counselling-psychology.eu>). Alternatively, as the British educational system is flexible, the establishment of a 'joint' counselling (and) health psychology training program could be an answer to the question. A first step might be the establishment of a special interest group within the Division of Counselling Psychology of the BPS, which will encourage the development of these efforts. Such a group is already operating within the Division of Clinical Psychology since 1998 (<http://www.bps.org.uk/dcp-facchp/>). On the other hand, in countries like mine, Greece, where PhD is strictly an academic title that requires no professional training, other solutions appear to be more appropriate: the inclusion of health psychology-related courses in the counselling psychology post-graduate curricula, or internship in health settings and on-the-job training might fit better.

It should be stressed, however, that post-graduate and doctoral training programs in Health Psychology, as a specific applied field of Psychology, has been established across Europe (e.g., in United Kingdom, The Netherlands, Portugal, Greece) for many years (for relevant information, <http://www.ehps.net>). The experience gained from these programs could be useful for the development of counselling health psychology training programs. After all, health psychologists and counselling psychologists can both work within the same medical settings in a complementary way.

Conclusion

Counselling health psychology, which refers to the science and practice of counselling psychology in the medical health related context, is a promising area for psychologists. As society and health care policy makers become more and more familiarized with the biopsychosocial perspective on health and illness, and as our work in medical settings becomes more effective, the opportunities for counselling psychologists in health care services will also grow (Layard, 2005). Counselling psychologists will eventually become an integral part of health care provision and, more important, patients will benefit from their presence and services. However, for a successful integration to take place, counselling psychologists must be properly educated. It is a challenge for training programs in counselling psychology to satisfy the emerging needs.

With continuing education and increased advocacy for integrated health care services, counselling health psychologists will meet their goals in providing improved services.

Besides the existing opportunities and difficulties, counselling health psychology is a field with a great future. Health care will be faced with a number of challenges in the near future. Changes in education and training, research and practice (e.g., in the areas of behavioural genetics, telehealth, women and minorities issues, organ transplantation) are already taking place. Within this context, counselling health psychology has a lot to offer and a lot to gain.

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Counselling Psychology and Disability

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Acknowledgements

The authors thank Jennefer D'Aubyn for her support with this article.

Abstract

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

Keywords: counselling psychologists; disability; school children; attitudes

Introduction

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

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

Method

Instrument & Procedure

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

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

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

Participants

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

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

Analysis

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

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

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

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

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

Results

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

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

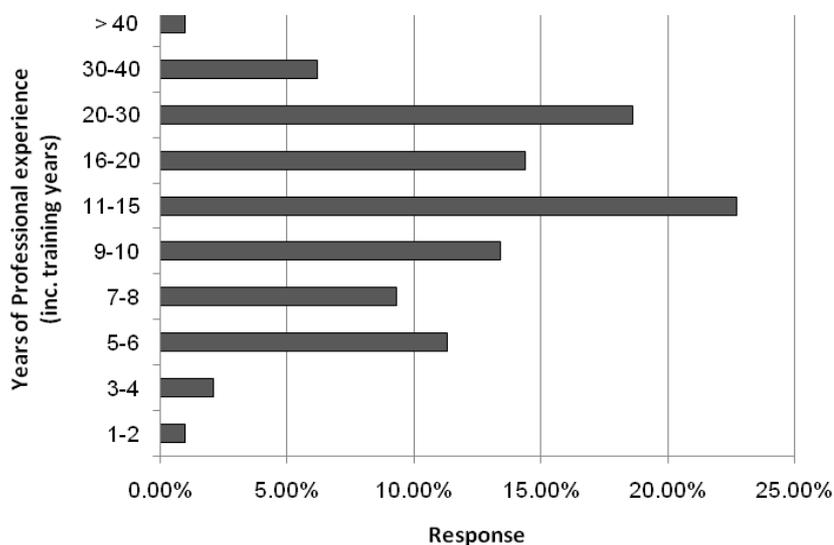


Figure 1 Respondents' professional experience in counselling psychology including training years

COUNSELLING PSYCHOLOGY AND DISABILITY

Work place

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

Table 1
Work place settings in which the respondents had experience

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

^a EAP = Employee Assistant Programme

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

Type of disabilities respondents reported to have worked with

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

Respondents' disability-related professional experience

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

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

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

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

COUNSELLING PSYCHOLOGY AND DISABILITY

Table 3

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

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

Table 4

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

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

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

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

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

Types of client work

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

Distribution regarding age groups

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

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

COUNSELLING PSYCHOLOGY AND DISABILITY

Table 5
The distribution of respondents' work across age groups

Distribution regarding age groups	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	5%	Response count
Working age (life) adults	24.4% (20)	18.3% (15)	14.6% (12)	9.8% (8)	1.2% (1)	7.3% (6)	3.7% (3)	3.7% (3)	3.7% (3)	9.8% (8)	3.7% (3)	83.67% (82)
Elderly	5.4% (2)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	8.1% (3)	0.0% (0)	0.0% (0)	37.8% (14)	29.7% (11)	37.76% (37)
Teenagers	5.6% (2)	2.8% (1)	0.0% (0)	2.8% (1)	0.0% (0)	0.0% (0)	0.0% (0)	16.7% (6)	16.7% (6)	44.4% (16)	11.1% (4)	36.73% (36)
School aged children	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	4.2% (1)	0.0% (0)	8.3% (2)	25.0% (6)	16.0% (4)		20.8% (5)	24.49% (24)
Preschool aged children	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	16.0% (2)	0.0% (0)	41.7% (5)	41.7% (5)	12.24% (12)

Table 6
Respondents' reported use of psychological models in their disability-related client work

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

Psychological models used when working with people with disabilities

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

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

Table 7
Respondents' reported estimated use of psychometric tools with clients with disabilities

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

Table 8
Respondents' reported use of various communication aids when working with clients with disabilities

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

Psychometrics

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

Use of communication aids when working with people with disabilities

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

Priorities

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

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

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

2. *Counselling Psychologist*. The concept of the therapist as a person refers to the human dimension of the profession. Indeed, some of the respondents were themselves disabled. In relation to this priority, the significance of *Awareness* was highlighted. Awareness includes:
 - a. The *Impact* of the client's disability on the counselling psychologist and the therapeutic relationship.
 - b. *Knowledge* of the particular physical health issues that are linked to the client's disability.
 - c. *Vigilance*
 - d. Personal perception regarding *Oppression*.
 - e. *Personal Assumptions*
 - f. The *Movements* of the counselling psychologist during sessions.
3. *Identity*, which included the *Ideology/Values* regarding social justice.
4. *Cognition* of the client and the counselling psychologist.
5. *Phenomenology* in relation to the contact of the counselling psychologist with the client. The respondents focused on their clients' and their own *Sense-Experience*, of which important components were:
 - a. The perception of *Life*
 - b. *Perceived Difficulties*, including the *Financial* difficulties associated with having a disability.
 - c. *Time*, where they prioritised the *Present* with respect to how it had been developed by the *Past*. At the same time, the direction was maintained towards the *Future* of the therapeutic relationship.

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

1. *Acceptance* of the disability, by the client as well as by the counselling psychologists. This was a requirement for *Coping/Healing*. Associated with *Acceptance* was:
 - a. The need for experienced *Humanity*, including within the therapeutic relationship.

- b. The *Adjustments* of the people with disabilities, the counselling psychologists themselves, and the whole environment regarding the existing challenges.
2. The concept of *Loss*.
3. *Change*
4. The increase in *Control*, of which people with disabilities are deprived.

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

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

1. *Breadth*
2. The *Social Context* in which the clients with disabilities live. Regarding this thematic sub-unit respondents also referred to:
 - a. *Organisational Context*
 - b. *Stigma*
 - c. *Systems*.
 - i. This was seen to impact on the *Inclusion/Exclusion* of people with disabilities, and a connection was made with *Access*.
 - ii. The *Dynamics* that influence other changes.
 - d. A *Relational* dimension which includes *Relational Complexity*, and *Intrapersonal Relationships*. The respondents compared the type of relationships that they develop with their clients with disabilities to other human relationships:
 - i. *Parents/Young Children* and the *Protectiveness* that comes with parenthood
 - ii. *Couples*

- iii. *Peers*
- iv. *Family*
- v. *Carers*

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

3. *Statutory Agencies, especially Schools.*
4. *Social Action.* Major concepts within which were *Legal, Intrapersonal Care, Political, and Helping.* The respondents appeared to help their clients through:
 - a. The *Therapeutic Relationship* – a broad key concept that fitted within *Helping.* Important priorities of the respondents were:
 - i. The *Communication* between the clients and their families as well as with the counselling psychologist. Important dimensions included:
 - *Information*
 - *Expression* or not of the clients' concerns. The concept of *Expression* comprised the *non-Explicit* information from the respondents to their clients.
 - *Clarity*
 - *Communication Restraint*
 - ii. The *Sharing* of experience through the therapeutic relationship.
 - iii. *Appreciation* of the individual in his/her own right. This priority appeared to be based upon the foundations of holistic *Respect*:
 - Towards the *Client* as a person.
 - In relation to the *Client's Priorities* and in collaboration with the client, and not to that of the counselling psychologist.
 - The *Sameness/Difference* of each individual in relation to others.
 - *Normalisation*, which was linked to *Alternative/ Adjustments.*
 - iv. *Care* included the *Ethics* of the respondents as responsible professionals, which came with:
 - *Responsibility*

- *Competence and its limitations*
 - *The necessary Training*
 - v. *Empowerment of the client*
 - vi. *Collaboration within the therapeutic relationship*
 - vii. *The necessary Trust/Safety*
 - viii. *The Ending of the intervention*
- b. *Assessment/Treatment* was an important element of helping clients in that of good *Assessment* was followed by the *Treatment* of people with disabilities. Important factors included:
- i. *The Model* on which the respondents had been basing their work with people with disabilities. It appeared that models were chosen based on the evaluation of assets rather than deficits.
 - ii. *The Efficacy* of treatment, in which contributed both the *Creativity* of the respondents and *Practice-based Literature*.
 - iii. *Cure* or its absence.
 - iv. *The Motivation* of all parties
- c. *Teach/Learn* was presented as a multi-directional process within which the client, the therapist, and the family shared knowledge.
- d. *Assist/Facilitate/Enable/ Support*, which included concept of the required Resources,
- e. *Dependence*
5. *Equality/Non-Discrimination*,
6. *Social Justice*,
7. *Financial Context* that affects people with disabilities

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

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

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

Discussion

Limitations and recommendations for future research

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

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

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

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

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

Years and areas of experience of European counselling psychologists

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

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

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

Main findings

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

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

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

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

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

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

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

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

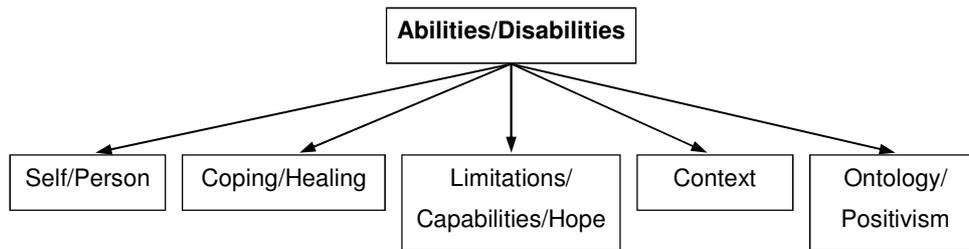


Figure 2 Conceptual tree developed by grounded theory analysis of the final question responses

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

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

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

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Appendix

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

SELF/PERSON

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

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

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

Client/Individual

The client as an individual (23)

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

...ideal self... (5)

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

Person-Centred

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

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

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

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

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

Emotions

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

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

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

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

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

COUNSELLING PSYCHOLOGY AND DISABILITY

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

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

Appearance

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

Lost Abilities

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

Behavioural

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

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

Wish of the client

ideal self (5)

...expectation. (21)

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

Quality of Life

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

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

Goals

Hear his wishes and needs... (7)

Clear goal planning... (19)

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

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

Requests/Demands

I ask them... (63)

Hear his wishes and needs... (7)

COUNSELLING PSYCHOLOGY AND DISABILITY

what they bring (57)

Needs

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

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

To respect their needs... (29)

Independence/ Functioning

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

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

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

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

Counselling Psychologist

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

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

My interest in disability is entirely personal. (51)

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

Awareness

awareness of the impact... (28)

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

Impact

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

Knowledge

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

Knowledge of particular health issues... (X)

Vigilance

Checks on effectiveness of therapy and providing feedback (13)

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

I also avoid the use of metaphor. (46)

Oppression

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

Assumptions

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

Movements

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

Identity

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

What identity the client has (23)

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

Ideology/Values

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

Cognition

Clear goal planning... (19)

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

How ic onsider issues... (37)

The client's perspective of their difficulties (23)

Phenomenology

Phenomenolical (67)

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

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

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

Sense-Experience

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

ease of access to appropriate services (58)

...pain issues... (17)

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

anxieties (68)

bereavement and loss (68)

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

...what is troubling them. (32)

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

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

...individual experience... (1)

Life

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

...maintain life affirming changes. (75)

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

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

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

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

Difficulties

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

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

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

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

Financial

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

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

ask for financial support. (32)

Time

Past and Present

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

Future

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

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

COPING/HEALING

Containment of affect (14)

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

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

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

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

Acceptance

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

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

The ability to accept and transcend these problems (62)

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

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

Trying to be non judgmental (40)

Humanity

shared humanity (70)

real relationships (70)

Normalisation of the human experience (55)

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

Adjustments

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

COUNSELLING PSYCHOLOGY AND DISABILITY

Adjustment processes (60)

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

only experience of one client with signing interpretor (31)

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

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

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

Loss

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

identity loss... (20)

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

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

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

Change

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

Control

...managing risk... (16)

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

LIMITATIONS/CAPABILITIES/HOPE

LIMITATIONS

Does it stop them from doing anything? (21)

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

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

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

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

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

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

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

Sense of Uncertainty

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

Risk

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

managing risk... (16)

Client Risk (66)

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

CAPABILITIES/HOPE

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

Strengths

self esteem (5 & 71)

confidence/competence (71)

...strengthen their existing abilities (11)

Finding strengths of client... (9)

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

CONTEXT

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

Breadth

...client's wider context... (54)

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

Social Context

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

COUNSELLING PSYCHOLOGY AND DISABILITY

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

...integrated social support. (75)

...environmental... (74)

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

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

Organisational Context

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

Stigma

...prejudice (20)

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

...psychological stigma... (60)

Systems

...systems thinking. (46)

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

Inclusion/Exclusion

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

...social inclusion... (1)

Access

ease of access to appropriate services (58)

...transport... (15)

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

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

Physical access to premises. (40)

Dynamics

...family environment/roles (25)

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

Power dynamics (67)

Relational

...relational focus. (74)

Without alliances... (75)

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

Relational Complexity

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

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

Intrapersonal Relationships

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

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

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

Without alliances... (75)

...relational focus. (74)

Parents/Young Children

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

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

Protectiveness

...as well as protectiveness. (35)

Couples

Intimacy and sexuality... (38)

Offering couples therapy... (76)

Peers

peer relations (5)

Family

family relations (5)

...family networks... (19)

Carers

...carers... (29)

Attachment

attachment (20)

Authenticity

real relationships (70)

Statutory Agencies

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

Social Action

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

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

Legal

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

Intrapersonal Care

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

Political

...the "politically correct" (29)

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

Helping

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

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

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

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

Therapeutic Relationship

Naming what is in the room (69)

...offering a trusting relationship (74)

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

Strong therapeutic alliance (13)

...relational depth (17)

Establishment of a safe therapeutic relationship (29)

COUNSELLING PSYCHOLOGY AND DISABILITY

Working together on issues... (X)

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

A joy in the therapeutic relationship (53)

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

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

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

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

Communication

...good communication (X)

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

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

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

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

only experience of one client with signing interpretor (31)

...providing feedback (13)

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

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

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

Information

Witness to their Narrative Containment of affect (14)

Discovering all relevent information. (27)

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

Expression

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

Clarity

communication and clarity (48)

Communication Restraint

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

Sharing

Sharing the experience with the client (27)

Appreciation

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

Respect

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

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

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

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

Priorities of the client

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

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

Sameness/Difference

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

...sameness vs difference (38)

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

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

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

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

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

Normalisation

Normalisation of the human experience (55)

Normalising (69)

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

Alternative-Adjustments

Adjustment processes... (60)

...adapt the session for that person... (63)

Care

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

Ethics

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

Responsibility

power and responsibility (48)

Competence

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

Training

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

Empowerment

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

Empowering the client disability or not (23)

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

Power dynamics (67)

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

empowerment self as own expert (47)

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

Identifying and amplifying personal strengths... (74)

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

Collaboration

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

Trust/Safety

Establishment of a safe therapeutic relationship (29)

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

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

Ending

Good endings... (13)

Assessment/Treatment

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

Model

Working alongside the medical model... (X)

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

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

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

Efficacy

Checks on effectiveness of therapy... (13)

Creativity

COUNSELLING PSYCHOLOGY AND DISABILITY

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

Practice-based Literature

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

Cure

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

Motivation

Motivating the client and others. (19)

Teach/Learn

Positive thinking (6)

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

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

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

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

Educate immediate environment... (6)

Assist/Facilitate/Enable/Support

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

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

...providing feedback (13)

...how service provisions can assist and facilitate client's development (16)

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

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

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

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

Resources

COUNSELLING PSYCHOLOGY AND DISABILITY

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

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

...the resources we have. (56)

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

Dependence

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

Equality/Non-Discrimination

...the client disability or not (23)

equal opportunities (41)

ensure equality in service... (15)

That the client receives equitable services. (37)

Social Justice

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

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

Financial Context

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

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

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

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

ONTOLOGY/POSITIVISM

Part-Whole

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

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

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

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

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

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

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

...their existing abilities (11)

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

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

Most of my clients... (32)

Knowledge of particular health issues... (X)

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

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

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

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

specific understanding of the disability... (28)

Degree

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

Good/Bad

Good endings... (13)

Understanding

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

...our exploration with clients and others. (21)

Understanding the client's perspective. (27)

care to be fully understood (65)

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

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

Reasons

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

Core

Core pain issues relational depth (17)

Valuing

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

Physical/Emotional

...physical disabilities... (24)

Physical access... (X)

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

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

Actions

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

Does it stop them from doing anything? (21)

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

...maintain life affirming changes. (75)

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

...address practical issues... (15)

Health/Illness

...factors whihc contribute to illness... (16)

Knowledge of particular health issues... (X)

...acquired brain injury... (24)

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

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