

THE EXPERIENCES OF INDIVIDUALS WITH PSYCHOLOGICAL DISABILITIES IN
ATTENDING COUNSELLING: A PHENOMENOLOGICAL INVESTIGATION

A thesis submitted in partial fulfillment of the requirements
for the degree of Master of Education in Educational
Counselling

Alyssa Max
School of Counselling Psychology
Faculty of Education
University of Ottawa

ACKNOWLEDGEMENTS

First and foremost, my deepest and heartfelt thanks to Dr. Audet, Dr. Dr. Paré, and Dr. Magnet, who offered their encouragement, expertise, and support throughout this project.

Four years is a long time to spend on a project. There are people who paved the way for this journey with whom my path has since diverged, but who I am still so grateful to: Mike, who brought me into the fold of activism and pushed me to put my anger to good use; Joanne, who mentored me in more ways than I count; Zivi, who reminded me how important my work would be to the people who matter; Ro, who helped me bring the darkest parts of myself into the light.

There's nothing like graduate school to teach you that the only thing more important than self-care is squad care. So much love to the squad who, in particular, helped me survive the last year: Anya, David, Dayna, Eddie, Gabi, Fateema, and Lucy. I have no doubt I couldn't have made it through without you. And an extra special thanks to Zoe, who has held my hand through all the twists and turns.

Many thanks, to all the Edwardses, Maxes, Ramjits, and Ameerallys, and my fairy godmother Jill. I am unendingly grateful for their wisdom, strength, hugs, and snacks. And of course, thank you to Norah Bean (and her Mom and Dad) for the belly laughs and kisses.

My sister, Meg, and my Mom, Deborah, are the reason I was able to do this research. If I am a social justice warrior, it is because, in their fierce desire to make the world better, they taught me how to fight.

To all the people who have shared their stories with me: thank you, from the bottom of my heart. I hear you. I see you.

Nothing about us without us.

ABSTRACT

The topic of disability within counselling is one that has received relatively little attention, despite counselling's focus on multicultural competencies. Some scholars argue that mental illness can be conceptualized as a disability, and that viewing it as such can provide important insight and empowerment to individuals dealing with these issues. In particular, exploring mental illness as psychological disability can provide a framework for understanding the impacts of both internal and external experiences of disability on the individual. This research draws on critical disability studies theory to frame psychological disability within a social-relational model, examining the potential impact of ableism and sanism on counselling clients with psychological disabilities. Three participants were interviewed using a semi-structured protocol to explore their experiences with counselling and psychological disability. Using interpretive phenomenological analysis, six main themes emerged: Embodied Difference, Meaning and Disability, Intersections of Identity, Emotional Labour, Language, and The Therapeutic Alliance. Implications for research, training, and practice include further exploration of intersectional identities such as gender and physical disability, and incorporating an understanding of the psycho-emotional dimensions of disability, including emotional labour, into counsellor education and practice.

TABLE OF CONTENTS

Chapter 1: Introduction to the Research	1
Personal Prelude	1
Conceptualizing Disability	2
Conceptualizing Psychological Disability	3
Thesis Overview	5
Chapter 2: Literature Review	7
Psycho-emotional Dimensions of Disability	7
Disability in Counselling Research and Practice	10
Chapter 3: Current Study.....	14
Interpretive Framework	14
Research Question	15
Chapter 4: Methodology	17
Methodological Framework	17
Research Instruments.....	19
Participants.....	21
Procedure	23
Quality and Trustworthiness	26
Chapter 5: Results.....	28
Participant Context	28
Thematic Categories and Themes	29
Theme 1: Embodied Difference	30
Theme 2: Meaning and Disability.....	33
Theme 3: Intersections of Identity	35
Theme 4: Emotional Labour.....	38
Theme 5: Language	43
Theme 6: The Therapeutic Alliance.....	45
Chapter 6: Summary and Discussion.....	51
Critical Reflections	51
Main Findings	53

Limitations	62
Implications for Research, Practice, and Training.....	62
Final Remarks	64
References.....	65
Appendix A: Demographic Questionnaire	72
Appendix B: Interview Protocol	73
Appendix C: Preliminary Reflexive Position	75
Appendix D: Social Media Recruitment Text.....	77
Appendix E: Study Description for Participants	78
Appendix F: Participant Recruitment Text.....	80
Appendix G: Eligibility Checklist	81
Appendix H: Consent Form for Study Participants.....	82

CHAPTER ONE

Introduction to the Research

In 2012, 3.8 million Canadian adults, or 13.7% of the adult population, reported experiencing a disability in Canada. Of these, 3.9% reported having a mental or psychological disability (Statistics Canada, 2012). In the same year, Statistics Canada also stated that 10.9% of the adult population had reported symptoms consistent with a mood, anxiety, or substance disorder in the preceding 12 months, and that 1 in 3 Canadians meet the criteria for one of these disorders in their lifetime (Pearson, Janz, & Ali, 2013). The Mental Health Commission of Canada (2013) estimates that nearly 20% of the Canadian population is living with a mental illness or mental health issue in any given year. These differing statistics, each using different requirements and measurements, illustrate the difficulty in defining psychological disorder and disability.

People with disabilities are specifically named as a minority group that training programs accredited by the American Psychological Association must include in their curricula (Olkin, 2012). Nevertheless, counselling as a discipline has failed to be attentive to issues of disability (Foley-Nicpon & Lee, 2012), and the lens of disability is frequently ignored when examining mental illness. As a result, the perspectives of clients with disabilities is largely absent from the counselling literature. This study aims to elevate the voices of clients and highlight experiences of disability by exploring the experience of counselling from the perspective of clients with psychological disabilities. I will examine how public and private experiences of psychological disability may impact the counselling experience by exploring how clients conceptualize, constructed, and experience psychological disability as a social and psycho-emotional phenomenon.

Personal Prelude

This research is inspired by my own personal experiences with mental health, and the discussions with others with lived experience that shifted my perspective towards an understanding of mental illness as psychological disability. During these discussions, I heard many stories about individuals' personal experiences with counselling, and the challenges they faced in finding counselling that reflected their own perspectives on their experiences. While the counselling literature—and indeed, the research literature as a whole—tells many stories of

client perspectives on counselling, the perspectives of those living with disability, particularly psychological disability, is lacking. Thus, this research focuses on exploring the topic of disability within counselling, and giving voice to counselling clients living with psychological disabilities.

This research is also inspired by my interest in social justice counselling. It is my belief that, in life and in counselling, the personal is political. Our lives are impacted by the world we live in, and a true understanding of mental health must include an understanding of how society impacts our well-being. It is my hope that this research will not only inspire more conversations about counselling and disability, but also working to change the circumstances that compromise client well-being.

Conceptualizing Disability

There is no universal definition of disability, and how disability is defined is inherently socially constructed (Olkin, 2011, p. 462). Statistics Canada (2012) defines disability as an impairing long-term condition or health problem causing limitations in an individual's daily activities or in certain tasks. Legal and governmental definitions, however, often differ from a theoretical understanding of disability. According to Olkin (2011), disability is "a fluid conception that can only be defined by the context in which it occurs" (p. 462).

A major source of contention within disability studies is the conceptual separation of impairment and disability. Impairment is understood to be the cause of a difference in ability to function or perform certain tasks, whereas disability is the mismatch between the ability to function and the environment. According to theorists who subscribe to a traditional social model of disability, disability resides in the environment and its accessibility or lack thereof, whereas impairment resides in the individual (Olkin, 2011). These theorists believe that divorcing impairment from disability is essential for equity and equality for people with disabilities. This conceptual divorcing, however, has received a great deal of criticism from those who point out that as the subjective experience of impairment is an essential part of the experience of disability for many disabled people, it is impossible to divorce the experience or concept of impairment from that of disability. Indeed, critics of the traditional social model argue that ignoring the experience of impairment also means ignoring the personal stories of people with disabilities, thereby contributing to the oppression of disabled voices (Mulvany, 2000; Thomas, 1999, 2001). Tierney (2002) illustrates this by pointing out that how an individual's disability is experienced

and constructed by *both* the individual *and* society is what will determine how society interacts with a disabled person. This is particularly relevant to people with psychological disabilities, for whom the experience of impairment can have serious deleterious effects on their ability to fully participate in the world around them (Tierney, 2002). Similarly, individuals with chronic pain have often been excluded from the conversations on disability due to the fluctuating and often unknowable nature of their conditions, as well as debates on whether chronic pain can be considered “impairment.” A theory of disability that includes *both* an understanding of disability as impairment *and* disability as social exclusion allows for the inclusion of groups who may not be traditionally considered “disabled” because of their failure to fall into the traditional medical model of disability, but who nonetheless experience impairment effects and/or social consequences as a result of their conditions.

This research thus adopts the stance of the relational social model of disability, a “both/and” approach advanced by Thomas (1999), who argues that the experiences of disability and impairment are inherently intertwined and cannot, and should not, be separated. Thomas (1999) subscribes to the definition of disability developed by the Union of the Physically Impaired Against Segregation (UPIAS), an early disability rights group from the UK. This definition frames disability as an experience that is inherently relational and involves both the experience of impairment and environmental barriers, defining disability as “the disadvantage or restriction of activity caused by a contemporary social organisation that takes no or little account of people with impairments and excludes them from the mainstream of social activities” (UPIAS, 1976, cited in Thomas, 1999). Thus, the word “impairment,” as it is employed in this research, refers to the differences in ability to function or perform certain tasks, including the symptoms of that difference. When the term “disability” is used in this research, by contrast, it refers to both the personal bodily and psychic experience of impairment as well as the public experience of barriers and the social response to impairment, and—perhaps most importantly—the interaction of the two.

Conceptualizing Psychological Disability

The ambiguity of its cause, its symptoms, and the various ways it may be categorized makes psychological disability difficult to understand or define. Outside of rehabilitation psychology, where the term *psychiatric disability* is a fairly common refrain, the concept of mental illness as disability is continually contested, in part because there is no universal

agreement about its aetiology or manifestation. Arguably, it is neither visible nor measurable and subjective definitions further contribute to confusion and misunderstanding (Hewitt, 2006). Even the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013), the handbook meant to aid professionals in diagnosing and delineating mental illness and disorders, is the subject of disagreement, and even animosity, between mental health professionals (Eriksen & Kress, 2006). An understanding of mental illness as disability is also complicated by disagreement amongst those who embody this experience about whether it constitutes a disability. Many individuals with mental illness are skeptical of the term disability, most often because they fear it will further stigmatize and devalue them in a world that already sees them as “damaged” (Beresford, 2000; Beresford, Nettle, & Perring, 2010; Price, 2013). In addition, many people view disability as a permanent condition, whereas mental illness may be fluctuating or occur for only a specific period of time. However, the inclusion of fluctuating or episodic impairments has been well documented in the disability literature, and it is generally agreed that permanence and/or consistency is not a requirement for inclusion within the category of “disability” (Olkin, 2011).

The difficulty around terminology among mental health service users is not limited to the binary of disabled/not disabled. Negative connotations around mental health terminology create significant barriers towards understanding and taking action when it comes to mental health (Beresford, Nettle, & Perring, 2010). Psychological disabilities exist with many names: mental disorders, mental illness, cognitive disability, consumer/survivor/ex-patient (c/s/x), neurodivergent, neuroatypical, crazy, or mad (Price, 2013). Price (2013) argues for the concept of “psychosocial” disability when discussing psychological disability, or even, humorously, “biopsychosocialpoliticalbodymind” disability (p. 304), in an attempt to acknowledge the numerous factors involved in the experience and negotiation of psychological disability and ableism. While Price eventually settled on the term “mental disability” (p. 305), she specified that this includes non-psychological forms of impairment that exist in the brain/mind, such as sensory or intellectual disabilities. As this research study focuses specifically on the experience of psychological impairments, the term psychological disability is employed here.

Definitions of psychological disability have often centered around individual pathologization. Avoiding definitions of psychological disability, however, has led to a lack of attention to the issue of mental health-related disabilities, and a lack of access to resources and help that many people have desperately needed (Watermeyer, 2012). While the definition of disability used in this research includes both impairment and social factors, definitions of psychological disability available in the literature tend to leave out the social barrier aspect. In addition, this research focuses on lived experience and self-identification, and, as such, requires a definition of psychological disability that is accessible and reflective of participants' understanding of their own experiences. As such, the definition of psychological disability used in this research is taken from the Canadian Psychiatric Association (n.d.):

Significant clinical patterns of behaviour or emotions associated with some level of distress, [suffering], or impairment in one or more areas of functioning (school, work, social and family interactions). At the root of this impairment are symptoms of biological, psychological or behavioural dysfunction, or a combination of these.

The theoretical orientation of this research is one that remains dedicated to a “both/and” understanding of disability, and as such this definition can be seen as falling under the wider umbrella of the aforementioned UPAIS definition that includes both social barriers and impairment effects, providing a more specific definition of the impairment effects experienced by people with psychological disabilities.

Counsellors frequently encounter clients dealing with mental health issues. Some of these clients may fall under various definitions of psychological disability or impairment. Other counselling clients may present with other types of disabilities, whether visible to the eye or not. Yet, as we have seen, conceptualizing and understanding disability is complicated, and the definitions of disability are often contested. What happens within the counselling room when the topic of psychological disability is broached can often be equally complicated, and is vital to explore if counsellors are to understand how best to work with these clients.

Thesis Overview

In the next chapter, I further introduce the research with a review of the relevant literature, examining the research on counselling clients with disabilities, generally, and psychological disabilities, specifically, as well as discussing intersectionality and the concept of psycho-emotional dimensions of ableism and sanism. In Chapter Three, I situate my research

within the interpretive framework of the relational social model of disability and psycho-emotional ableism and introduce the research question. In Chapter Four, I discuss the methodology of the research, starting with the methodological framework of interpretive phenomenological analysis. I then present the research instruments and research procedure, and discuss quality and trustworthiness in the context of the research. Chapter Five introduces the results, beginning with an examination of the participants' contexts, and then exploring the thematic categories and themes. In Chapter Six, I present a summary and discussion of the findings, beginning with my own critical reflection and then exploring the main findings theme by theme, situating these findings within the wider body of literature. I conclude with an exploration of the implications of the results for research, practice, and training.

CHAPTER TWO

Literature Review

The literature review will start with a discussion of the psycho-emotional dimensions of disability, exploring how the interpersonal and intra-personal impact of living with disability is vital to understanding the counselling process. I will then discuss intersectionality within the context of disability, and the impact of different identities on the experience of psychological disability. Finally, I will discuss disability in counselling research and practice, ending with a specific exploration of psychological disability and current recommendations for working with psychological disability in counselling.

Psycho-emotional Dimensions of Disability

Disability and ableism. Campbell (2008) defines ableism as “a network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as perfect, species-typical and therefore essential and fully human” (p. 153). According to Goodley, Hughes, and Lewis (2012), “ableism denotes the meaning of a healthy body, a normal mind, how quickly we should think and the kinds of emotions that are okay to express” (p. 10). A specific standard for acceptable bodies or minds and how they should function exists in many cultures in our world today, including Western society—a society that operates in favour of and in service for non-disabled people. Ableism manifests in a multitude of ways, both institutionally and personally. This section will focus on inter- and intra-personal manifestations of ableism, conceptualized by relational social model theorists as “psycho-emotional dimensions”: how ableism operates on psychological and emotional levels to undermine the well-being of people with disabilities (Watermeyer, 2012).

According to Marks (2002), the concept of disability is “invested with fears and fantasies that operate at a cultural, an interpersonal, and ultimately an intra-psychic level” (p. 3). Theorists argue that disability is, at least on an unconscious level, personally threatening and brings a high awareness of vulnerability and feelings of fear, both for the person with the disability and those around them (Marks, 2002). According to Watermeyer and Swartz (2008), society prohibits the true expression of negative emotion about the experience of disability because of the anxiety and discomfort this would cause abled people. The prohibition of anger is also often a prohibition against a true expression of the authentic experience of disability. Individuals with disabilities live not only with the reality of their impairment, but must also navigate a social world that

views them as inadequate, unequal, and often threatening. As a result, many people with disabilities have become experts at managing others' reactions to their impairment in order to survive the effects of ableism. This may take the form of trying to minimize the visibility of one's disability, denying one's experiences of disability, or ignoring ableist comments or behaviours—in essence, trying to make oneself look or feel “less disabled” in order to fit into a world that has a negative view of disability (Olkin, 2011; Prilleltensky, 2009).

Connected to the management of the reactions of non-disabled people is the concept of internalized oppression. Reeve (2002) uses critical psychoanalysis to explain internalized oppression as “the projection of the disavowed parts of non-disabled people onto disabled people who are constituted as Other” (p. 495). Reeve asserts that disabled people are on the receiving end of non-disabled people's projections of fear, uncertainty, and disgust, which disabled people then internalize as part of their own understanding of self. Disabled people may respond to internalized oppression by conforming to social expectations of the “disabled role” in an attempt to make themselves more acceptable in the eyes of non-disabled people. However, in the case of people with invisible disabilities, such as those with psychological disabilities, the cultural message that disability is “bad” may motivate these individuals to hide or disguise the severity of their impairment, to “pass” as normal (Tierney, 2002; Watermeyer & Swartz, 2008). They may also develop damaging views of themselves as a result of this cultural message.

Psychological disability and sanism. While blanket stereotypes about individuals with disabilities certainly exist, the nature of individuals' disability will have a great impact on how it is experienced by those around them (Tierney, 2002). People with psychological disabilities may experience a specific form of ableism called “sanism.” Sanism “describes the systematic subjugation of people who have received ‘mental health’ diagnoses or treatment” (Poole et al., 2012, p. 20). According to Poole et al. (2012), sanism is a prejudice based on “how [individuals segregate their] emotions, thoughts, and behaviours from those labeled with a mental disability” and is supported by media portrayals and “gut feelings” (p. 25). Sanism results in both obvious discrimination and (more commonly) microaggressions, including low expectations of people with psychological disabilities or expectations that they are incompetent, irrational, or violent (Poole et al., 2012). One example of this is the common belief that people with mental illness are likely to commit violent crimes, when in reality they are more likely to be the victim of this type of crime than the perpetrator (Corrigan & Watson, 2002).

Descriptions of the inter- and intra-personal experiences of sanism are scattered across disciplines within the literature, and remain largely underexplored within the mental health field. The concept of “mental health stigma,” however, has been well documented and discussed. Research by Corrigan and Watson (2002) suggests that there are three main iterations of stigmatizing attitudes: fear and exclusion (people with mental illness are dangerous), authoritarianism (people with mental illness have weak character), and benevolence (people with mental illness are childlike and inspiring). These three categories parallel more general ableist attitudes towards people with disabilities: fear and disgust, blame and victimhood, and “inspiration” for “overcoming” impairment. Knight, Wykes, and Hayward’s 2003 exploration of the experiences of stigma among people living with schizophrenia give voice to the sanist attitudes that people with schizophrenia encounter, in public and private. Participants revealed that friends, family, public, and even medical professionals they encountered demonstrated sanist attitudes. The interpersonal and intrapersonal effects of stigma were severe for these individuals, a finding that has been validated by other studies examining stigma and the experience of psychological disability (Lester & Tritter, 2005; Tierney, 2002; Wahl, 1999).

The effects of ableism, sanism, and internalized oppression can even be seen within the disability community. Many individuals with mental illnesses do not wish to see themselves as disabled, or do not feel that they “deserve” the label because they “do not look the part.” In addition, mental illness is often stigmatized by those within the disability community who do not wish to be associated with the various negative connotations that come with it, including violent or bizarre behaviour (Beresford, 2015; Tierney, 2002). For these reasons, individuals with psychological disabilities also tend to fall on “the bottom of the hierarchy” in terms of disability or impairment (Tierney, 2002, p. 15). Some psychological disabilities, such as eating disorders, may also be seen as “self inflicted,” not only influencing how other disabled people view them but also influencing how they are treated by medical professionals (Tierney, 2002).

Intersections in psychological disability. In their examination of a critical anti-oppression paradigm of mental health, Holley, Stromwall, and Bashor (2012) argue that many of the explorations of experiences of mental illness ignore the complexity of historical, social, and political context. According to the authors, “social locations are critical areas of emphasis, with recognition that multiple group memberships [...] lead to different experiences with privilege, oppression, and opportunities for resistance related to one’s perceived mental health status” (p.

58). This argument is premised on the concept of intersectionality, a feminist and critical race theory originally developed to understand the experiences of black women. Intersectionality “simultaneously consider[s] the meaning and consequences of multiple categories of identity, difference, and disadvantage” (Cole, 2009, p. 171). Until recently—like many other areas of activism and research—intersectionality rarely included analyses of disability (Barnartt & Altman, 2013). Nevertheless, an acknowledgement of the impact of multiple social locations, or “statuses,” is critical when considering the lived experience of people with psychological disabilities. The experience of disability in general, and psychological disability in particular, may vary widely depending on a person’s gender, sexuality, race, class, or other disability status. This is supported by research demonstrating that, in America, black patients have a higher rate of misdiagnosis than white patients (Adebimpe, 1981), and are less likely to receive adequate treatment for mental health issues (Wang, Demler, & Kessler, 2002); that, as minorities, the LGBTQ community have higher rates of mental illness due to “minority stress” (Meyer, 2003); and that disparities exist in accessing mental health care across ethnicity, culture, socioeconomic status, race, and gender (Nelson, 2006). Thus, it is important to acknowledge, when examining issues of disability and mental health, that disability is a single factor in a web of identities, that it may interact with other identities and experiences, and that it is imperative not to erase these other experiences at the expense of understanding the stories and voices of people with psychological disabilities.

Disability in Counselling Research and Practice

Disability is an enormous category that includes a diverse range of impairments from within the mental health sphere, a topic crucial to counsellors. However, literature on people with disabilities within counselling has lagged considerably. Historically, disability was considered the domain of rehabilitation psychology, and was ignored by other counselling-related disciplines (Foley-Nicpon & Lee, 2012). Despite its commitment to social justice, multiculturalism, and diversity, particularly considering the continued marginalization of disabled people, counselling as a discipline has failed to be attentive to issues of disability. This is reflected in the fact that no major publications within counselling have a disability focus. A 20-year review of disability in the counselling literature completed by Foley-Nicpon and Lee (2012) revealed that disability-related research comprised only 1% of articles within five major counselling journals between 1990 and 2010, with a slight upward trend in the last five years.

This level of inquiry is minimal compared to other issues of diversity, including acculturation, social class, and multicultural counselling competency. There is also a lack of research, coursework, and practical experiences involving disability in counselling programs (Foley-Nicpon & Lee, 2012). People with disabilities are specifically named as a minority group that training programs accredited by the American Psychological Association must include in their curricula. Nevertheless, most graduates of counselling programs are not competently trained to provide services to clients with disabilities (Cornish, Gorgens, & Monson, 2008; Olkin, 2011). According to Foley-Nicpon and Lee (2012), “This practice within counselling psychology suggests at worst an exclusionary atmosphere toward people with disabilities and at best limited awareness about empirically based practices for assessment and intervention” (p. 393). The erasure of people with disabilities is so engrained in society that it often goes unnoticed or is implicitly considered acceptable. This unacknowledged erasure can affect counsellors’ attitudes towards and interactions with people with disabilities without the counsellor even realizing, making disability-specific training for counsellors particularly vital (Johnson, 2011).

Research into the experiences of clients with disabilities, including psychological disabilities, in utilizing counselling services has revealed that a therapists’ expertise with regards to a client’s issue is extremely important to the client (Coursey, Keller, & Farrell, 1995). Clients report often having to teach the therapist about their specific disability. Therapists who took it upon themselves to self-educate had better client outcomes, as did therapists whose conceptualization of disability was in line with that of their clients (for instance, therapists who did not just see mental illness as a “brain disease” were rated better by clients with serious mental illness) (Coursey, Keller, & Farrell, 1995; Hunt, Matthews, Milsom, & Lammel, 2006). Studies also show that basic issues such as physically accessible spaces are still an issue for many people with disabilities pursuing counselling. In a study on the experiences of lesbians with physical disabilities in counselling, a majority of participants reported having accessibility concerns during their work with their counsellor (Hunt, Matthews, Milsom, & Lammel, 2006).

Practitioners are beginning to consider these client perspectives in discussing how counsellors can and should work with clients with disabilities. Rhoda Olkin—herself a woman with a disability—is by far the most prolific writer on disability-related topics in the counselling field. She has created Disability-Affirmative Therapy (D-AT), a model through which counsellors can approach their client’s experiences of disability in ways that are anti-ableist and

consistent with the client's own internal model. D-AT operates based on the traditional social model of disability, and assumes there is no *adjustment* to disability, only a *response* to it, which is ever-changing (Olkin, 2011). Olkin specifies that D-AT requires special skills and training for all counsellors, and that it is a form of cross-cultural counselling when able therapists are working with disabled clients. Johnson (2011) echoes Olkin's recommendation for an approach that is centred on client's feelings and experiences, recommending a person-centred approach to working with clients with disabilities. Johnson specifically discusses the psycho-emotional effects of ableism and how they place "conditions of worth" on people with disabilities. She asserts that person-centred counselling, which involves unconditional positive regard, can help clients move past these conditions of worth and feel accepted by their therapists, leading to self-acceptance (Johnson, 2011).

Psychological disability in research and practice. Cornish, Gorgens, and Monson (2008) point out that it may be difficult for practitioners to recognize mental illness as a disability because of how often they encounter it in their everyday work. While practitioners receive training on mental illness, this training is unlikely to include mental illness as a disability or the sociopolitical implications. In addition, those within the counselling profession who consider themselves focused on social justice may attempt to bypass the concept of mental illness and disability altogether. In a press release on the American Counselling Association's task force on the DSM-5, staff liaison Rebecca Daniel-Burke wrote: "In general, counsellors are against pathologizing or 'medicalizing' clients with diagnoses as we prefer to view clients from a strength-based approach and avoid the stigma that is often associated with mental health diagnoses" (ACA, 2011). Practitioners who avoid diagnosis as a way of avoiding stigma, rather than challenging the stigma inherent in receiving a mental health diagnosis, may unintentionally be complicit in perpetuating that stigma. The implication that receiving a diagnosis—which is, essentially, a label for a set of symptoms experienced by an individual—is inherently a negative thing feeds into the belief that the experience of those symptoms is negative, or worthy of stigma. Focusing on avoiding diagnosis, rather than attempting to de-stigmatize the experience of mental health symptoms and remove the negative association, perpetuates the notion that the experience of mental health symptoms is inherently negative. Avoiding clinical diagnosis may also mean limiting an individual's access to treatment and accommodation.

Clinical diagnosis, however, does not solve the problem of stigma. According to Eriksen and Kress (2006), while a clinical diagnosis may positively change a counsellor's feelings towards the client, leading to less critical behaviour and more support, "diagnosing, like counselling, is a political act; that is, it is one that involves power in relationships and is performed in value laden political and contextual environments" (p. 205). The act of diagnosing requires making a judgement about what is normal versus abnormal emotion and behaviour, an act that requires value judgement (Eriksen & Kress, 2006). In addition, many clients labelled mentally ill are considered "difficult patients," and may be treated less compassionately or seen as less worthy of attention. This is particularly likely in the case of clients with conditions seen as untreatable (such as personality disorders) or self-inflicted (such as eating disorders) (Tierney, 2002). According to Corrigan and Watson (2002), even trained mental health professionals often subscribe to stereotypes about mental illness. This has been confirmed by several studies (Lauber, Nordt, Braunschweig, & Rossler, 2006; Rao et al., 2009) that show that professionals hold prejudicial attitudes towards individuals with certain types of impairments (schizophrenia, substance abuse disorders) and towards clients whose symptoms are rated as more severe. Thus, even the professionals meant to help those experiencing psychological disability are not immune from stigmatizing attitudes and implications.

CHAPTER THREE

Current Study

Interpretive Framework

The discipline of psychology is relatively new to the interdisciplinary field of disability studies. With a history of conceptualizing disability as “abnormal” or “special,” psychology has traditionally contributed to the segregation of disability from the mainstream (Olkin & Pledger, 2003). Certain areas of psychology and counselling literature, however, have attended to a shift towards disability justice. Writings in critical psychology have urged the highlighting of social justice and diversity and advocate for work to change social conditions that are harmful to wellbeing (Prilleltensky, 2009). Critical psychology, along with critical disability studies, operates on the assumption that society itself is disabling—that “barriers to full inclusion for people with disabilities are largely rooted in unaccommodating structures and social arrangements” (Prilleltensky, 2009, p. 251). Critical psychologist Isaac Prilleltensky (2008) coined the term “psychopolitical validity” to refer to the “inseparable nature of psychological and political dynamics and the need to attend to both” (Prilleltensky, 2009, p. 259).

The critical understanding of disability in this research study is grounded in the relational social model, which embodies the feminist ideal of the “personal as political” by theorizing that personal experiences of disability are socially constructed and that public and private experiences of disability are inherently intertwined (Thomas, 2001, 2011). Relational social model theorists argue that without an exploration of private and personal experiences, a full understanding of the diverse and varied lived experience of disability is impossible. According to Thomas (2001), only a focus on the personal experience of disability allows ableism to come fully into view.

Relational social model theorists have focused on the personal experiences of disability in order to explore the subjective, internal experiences of ableism that operate at the emotional level, referred to as a “psycho-emotional approach to ableism.” This theory is an emancipatory approach drawing from liberatory and feminist psychologies, often paired with critical psychoanalysis in order to examine the psychological experience of ableism, discrimination, and othering. This perspective differs from many other analyses of disability and ableism as it focuses specifically on the psychological experience of ableism—both on the part of the disabled person and of the abled person enacting ableism in society (Watermeyer, 2012).

According to Watermeyer (2012), the experience of impairment places disabled individuals on an altered trajectory of interpersonal and intrapersonal life. Reeve (2002) argues that ableism that operates at a social/interpersonal level can be just as disabling as the structural or institutional barriers more commonly discussed by social model theorists, and that such experiences of ableism negatively affect the emotional wellbeing of disabled people. As previously discussed, this may occur when ableism/sanism is enacted by others—conceptualized in much mental health research as “stigmatizing attitudes”—as well as when it is internalized by the disabled individual herself (“self-stigma”). Research on stigma and self-stigma lend credence to the claims these theorists have made about the deleterious effects of psycho-emotional ableism: research has shown that people with psychological disabilities experience low self-esteem and feelings of self-efficacy as a result of being devalued by society (Corrigan & Watson, 2002).

Psycho-emotional ableism ultimately prevents disabled people from experiencing true authentic interaction and acceptance (Watermeyer & Swartz, 2008). The prohibition of authentic expression and the deftness with which people with disabilities must navigate other’s reactions brings forward difficult questions for counsellors working with people with disabilities. As Watermeyer and Swartz (2008) state: “All humans require validation and acknowledgement, particularly of our more painful and difficult experiences, in order to foster self-compassion and acceptance” (p. 602). Counselling offers an opportunity for such validation and acknowledgement; yet, the counselling room does not exist in a vacuum, and psycho-emotional ableism and its effects may certainly be present in such emotionally-laden relationships as those between client and therapist. Indeed, exploring clients’ experiences of psycho-emotional ableism can help further uncover the power differentials between disabled and non-disabled people (Reeve, 2002). Thus, this project aims to frame the experiences and interactions within the counselling room through an understanding of psycho-emotional experiences of sanism, to understand how clients with psychological disabilities construct their experiences with counselling and counsellors through the lens of their disability experiences.

Research Question

This project’s main purpose is to understand, through qualitative interpretative phenomenological analysis, the embodied experiences of therapy of individuals with psychological disabilities who have used counselling services to address experiences related to

their disabilities. The research question is: *How do counselling clients with psychological disabilities construct their experiences within counselling and with counsellors through the lens of their disability experiences?*

CHAPTER FOUR

Methodology

Methodological Framework

Phenomenological research focuses on issues of lived experience, including embodiment, identity, and meaning. Phenomenology involves not just accessing an “inner world” but an individual’s relationship with the world. Phenomenological researchers view body-self-world as intertwined and take a view of life that is holistic and non-dualistic (Finlay, 2011). Smith, Flowers, and Osborn (1997) point out that phenomenology provides a particularly helpful framework for examining “the meaning of embodied experience in health and illness” (p. 54) by transcending the mind-body dichotomy and instead viewing the dynamic and reciprocal relationship between the self and environment and as entirety of the “phenomenological self.” Although phenomenology is often seen as a methodology that focuses on individual and private experiences, “the meaning of this experience is embedded in the context of an environment which is both social and physical” (Smith, Flowers, & Osborn, 1997, p. 53). That is, the environment mediates the relativity of individual experience. For the purpose of this study, I will apply a phenomenological approach, more specifically that of interpretive phenomenological analysis.

Interpretive Phenomenological Analysis. Interpretive phenomenological analysis (IPA) aims to explore, in detail, the experience of a specific event, process, or relationship within a participants’ personal or social world (Larkin, Watts, & Clifton, 2006). This approach has its conceptual underpinnings in hermeneutic phenomenology, based on the philosophies of writers such as Heidegger and Merleau-Ponty (Larkin & Thompson, 2012), which focuses on the subjective experience of a person as they are in the world and the interpretive exploration of this experience. Unlike the early phenomenological philosophers, Heidegger and his contemporaries reject the idea of bracketing out personal opinions or interpretations, arguing that removal of the researcher’s bias is impossible. Instead, hermeneutic phenomenology accepts that “interpretations are all we have” (Kafle, 2011, p. 187) and utilizes the hermeneutic circle to get to the heart of subjective experience (Kafle, 2011). The hermeneutic circle requires a researcher to move between their pre-understandings towards interpretation and back again. This can also be understood as “a dialectic movement between understanding (a nonmethodic pole) and explanation (a methodic pole)” (Lindseth & Norberg, 2004, p. 149). Thus, hermeneutic

phenomenology acknowledges the existence and importance of a researcher's own presuppositions in phenomenological understanding (Willig & Billin, 2012). Hermeneutics underscores the fact that “while phenomenology might be descriptive in its inclination, it can only ever be *interpretive* in its implementation” (Larkin & Thompson, 2012, p. 102).

Similar to hermeneutics, IPA uses an ideographic approach, with a focus on the specific experience of the “person-in-context.” Where IPA differs from traditional hermeneutic approaches is in its use of double-hermeneutics—incorporating the researcher's own sense-making of participants' making sense of their personal experiences (Larkin & Thompson, 2012). IPA attempts to understand the experience of the participants from their perspective. However, IPA also allows the researcher to ask critical questions as another entry point to understanding (Smith & Osborn, 2008). When engaging in a phenomenological approach, the IPA researcher is dynamic, attempting to gain an “insider perspective,” while still being aware of, and relying on, her own frameworks and conceptions in order to interpret and make sense of the personal world of the participant. IPA attempts to discover meaning through a joint reflection of both researcher and participant—making the process of meaning-making inherently intersubjective—and acknowledges that the inquiry process of the researcher inherently complicates the understanding and interpretation of phenomena (Smith, Flowers, & Osbor, 1997; Smith, Jarman, & Osborn, 1999). IPA also acknowledges the necessity of the researcher's own conceptions and interpretive lenses in order to make sense of the research (Smith, Jarman, & Osborn, 1999).

At its very core, phenomenology is the study of lived experience—what a group of individuals experienced and how they experienced it. A phenomenon is defined simply by van Manen (1990) as an “object of human experience” (p. 163). Dahl and Boss (2005) argue that a phenomenon can only be defined by “describing its essential impact on our immediate conscious experience” (p. 63). The phenomenon being examined in this study is the experience of counselling as an individual with a psychological disability, specifically, how a history of psychological disability influences how a client understands their experiences with counselling. Thus, this study aims to understand *what* individuals with psychological disabilities experience in counselling, and *how* they construct their understanding of these experiences.

Rationale for IPA. IPA is particularly popular within the field of health psychology in the UK, and with many researchers employing it to examine experiences of illness, IPA has been recommended for use in counselling psychology (Finlay, 2011, p. 139). In particular, several

studies across disciplines have used IPA to examine the experience of mental illness (Knight, Wykes, & Hayward, 2003; Lester & Tritter, 2005; Mulveen & Hepworth, 2006; Shineburn & Smith, 2009) and Larkin and Thomson (2012) argue that IPA's focus on understanding participant's experience can allow for research that is inclusive, rather than exploitative, of mental health service users. This point is particularly important given the traditional exploitation of marginalized groups, including those with disabilities, in the name of research. In their discussion of psychiatric research, Russo and Beresford (2015) describe how those with psychiatric disabilities often hand over their stories and knowledge, only to have them repurposed to serve a researcher's agenda, alienating those the research is meant to serve. These writers argue that researchers have the "professional power to shape psychiatric narratives," and the opportunity to authenticate and legitimize the experience of those with psychological disabilities (Russo & Beresford, 2015).

While there is still the danger of personal bias within the double-hermeneutic stance used in IPA, the method is, at its core, based on the concept of allowing the interviewee to "tell their own story, in their own words, about the topic under investigation" (Smith, Flowers, & Osborn, 1997, p. 68; Smith, Jarman, & Osborn, 1999). Phenomenology is potentially transformative in that it gives participants the opportunity to 'give voice' to, and make sense of, their experiences. According to Hewitt (2006), narratives of experiences of psychological disability help bridge the gap between these private experiences and the public consequences. In addition, phenomenology as it relates to illness highlights the altered experience both of one's body and one's world and "how these are one and the same" (Finlay, 2011, p. 33). This is consistent with the feminist disability theorists who contend that disability and impairment, personal and public, are inherently intertwined. IPA's focus on telling a participant's story, paired with the intersubjective process of meaning-making it affords, mirrors the exploration of the inherently intersubjective experience of psychological disability within the counselling room, while remaining consistent with a framework that focuses on elevating the voices of participants when they speak about personal, embodied experiences (Smith, Flowers, & Osborn, 1999).

Research Instruments

Two research instruments were developed to guide data collection: a demographic questionnaire designed to collect information about participant characteristics, and a semi-structured interview protocol that guided the interviews with participants. In line with the

double-hermeneutic stance of IPA, I myself, as researcher, am also considered as a research instrument.

Demographic questionnaire. A brief demographic questionnaire (Appendix A) was constructed to collect information about participants, including gender, age, ethnic background, level of education, and experiences with psychological disability and counselling. This allowed me to place the stories of participants in context, providing an examination of the homogeneity/diversity of the sample, and supporting the interview by providing background information on the participants' experiences with psychological disability and counselling so as to ensure the interview was as specific and sensitive to participants' individual experiences as possible.

Interview protocol. IPA requires a flexible data collection instrument that allows for engaging dialogue and an ability to wander "off the path" to explore areas of importance or richness to participants. A semi-structured interview allows for the interviewer to be "guided by the schedule, rather than dictated by it." Questions enable the establishment of rapport with the participant, and the interviewer is able to explore areas of interest or importance that may not have been specified within the pre-set interview questions. In this way, participants are more active in directing the line of questioning, and are given the opportunity to tell their own story (Smith & Osborn, 2008).

The writings of Smith and Osborn (2008) on constructing interview questions and protocols for IPA research provided guidance for the construction of the semi-structured interview protocol that was used in this study. The protocol (Appendix B) is divided into three sections that focus on participant's experiences with and perceptions of counselling and disability: (a) before counselling (e.g., "What does disability mean to you?"; "What were your expectations of counselling before you began?"); (b) during counselling (e.g., "How did you help your counsellor understand your experience with disability?"; "What did you and your counsellor do to work on the issues that brought you to counselling?"); and (c) after counselling (e.g., "How do you feel about your experience with counselling?"; "How did you feel about disability after attending counselling?"). Inspiration for the protocol questions was drawn from several sources, including Watermeyer's (2012) key questions on the "distorted social and psychological predicament of disabled people," Olkin's (2011) guidelines for Disability-Affirmative Therapy, and a study conducted by Coursey, Keller, and Farrell (1995) on the

experiences of people with serious mental illness in utilizing psychotherapy services. A previous protocol I developed for a pilot study on the experiences of people with psychiatric disabilities in using counselling services, conducted for a research class from September to December 2014, was also used to inform the development of the new questionnaire.

Researcher. In unstructured or semi-structured interviews, the researcher herself is as much the instrument as the questions she asks. For this reason, the attributes of the researcher will inevitably affect the collection of data. A common way to better understand this process is through reflexivity (Pazella, Pettigrew, & Millery-Day, 2012). Thus, in line with efforts to ensure confirmability (see “Quality and Trustworthiness,” below), as well as the double-hermeneutic stance of IPA, I kept a journal during the research project with reflections on the research process, including recorded reflections and notes after each interview and during the data analysis process. A preliminary reflection on my pre-understandings of the topic, written before data collection began, can be found in Appendix C. Additional reflections on the research process and results were incorporated into the “Personal Prelude” in Chapter 1 and “Critical Reflection” in Chapter 6, with the aim of establishing transparency and providing an understanding of how my personal experiences, assumptions, and interpretations may have influenced the research process.

Participants

Sample size. Due to the time-sensitive nature of thesis work, as well as the intensive nature of qualitative research, a smaller number of participants was considered more appropriate for this project. Three to six participants is generally seen as a reasonable sample size, with Smith and Osborn (2008) recommending three participants for beginner researchers at the Master’s level (Finlay, 2011, p. 141), as there is opportunity for extensive engagement with each participant and chances of convergence and divergence between participants, without an overwhelming sample size (Smith & Osborn, 2008). The aim was to recruit three to six participants. Four participants were initially recruited, with three completing the interview process.

Snowball sampling. According to Patton (2002), snowball sampling can be particularly useful for identifying hard-to-reach, information-rich participants when studying sensitive topics. Thus, a sample of participants was recruited using the snowball sampling, through social media and word-of-mouth (see Appendices D and F for recruitment material).

Inclusion Criteria. Inclusion criteria were two-fold: self-identification as living with a psychological disability, and experience with counselling for the purpose of discussing psychological disability. As previously discussed, disability is not easily defined, and is influenced by understandings of the body, the psyche, and society (Marks, 2002). Allowing people to the right to self-definition, which is a crucial point in critical disability studies, was a cornerstone of this research. Nevertheless, some sort of defining criteria are necessary. Thus, the definition of psychological disability used for inclusion, which has been used by the Ontario Human Rights Commission, is taken from the Canadian Psychiatric Association (n.d.):

Significant clinical patterns of behaviour or emotions associated with some level of distress, [suffering], or impairment in one or more areas of functioning (school, work, social and family interactions). At the root of this impairment are symptoms of biological, psychological or behavioural dysfunction, or a combination of these.

As previously discussed, this definition focuses on impairment effects so that participants may see their experiences or symptoms reflected, without requiring them to identify with an understanding of the social model of disability that also involves social barriers. The aim of this was to include a diverse representation of individuals who identified with the impairment effects of psychological disability, without biasing the results by requiring participants to have an understanding of disability in line with the theoretical orientation and pre-understandings that underline this research.

Participants were also required to have participated in a minimum of three one-on-one personal counselling sessions, excluding career- or academic-based counselling, with a certified mental health professional, for the purpose of discussing issues related to their psychological disability. In general, research on client experiences of counselling have focused on interviewing clients who have more counselling experience to ensure there is sufficient material for discussion; however, requiring participants to have had many counselling sessions may bias participation towards clients who had more positive experiences, excluding those who chose not to return to counselling because of negative experiences or other barriers (Henkelman & Paulson, 2006). Sessions were also required to have place within the past five years, and preference was to be given to participants who had engaged in counselling for a longer duration. Again, research has shown that it is beneficial to interview participants whose sessions had occurred in the recent past in order to provide

more accurate and detailed interview data (Henkleman & Paulson, 2006; Hodgetts & Wright, 2007). Thus, participants who had engaged in counselling for a longer duration were given priority in order to ensure the interviews could be as rich as possible. However, the aforementioned concerns regarding potentially biasing the results by excluding participants with fewer sessions were noted during participant selection.

Exclusion criteria. Exclusion criteria included participants who were minors or otherwise unable to give their own consent to participate in the study, the presence of a significant language barrier, and the existence of a reason to believe that participation in the research would cause them harm. Participants who were currently attending counselling were also excluded from the study in order to prevent interference with current counselling work.

Procedure

Participant recruitment. Following ethics approval from the University of Ottawa, the social media recruitment text (Appendix D) was posted on my personal Facebook page, with a request for any followers who were interested or believed they may know someone who would like to participate to share with interested parties. The text included inclusion criteria to aid potential participants in self-selecting.

Participant screening. When contacted by potential participants via e-mail, I provided them with the study description (Appendix E) and the participant recruitment text (Appendix F). Participants who agreed to participate in the study and believed they met the selection criteria were then e-mailed a set of screening questions to ensure their eligibility to participate (Appendix G). Of the nine participants who contacted me, eight expressed interest in participating in the study, but four were currently attending counselling and thus excluded from participating.

Data collection. Participants who met the screening criteria were formally invited to participate in the study and e-mailed a copy of the consent form (Appendix H) to review. Participants who consented to participate were then contacted to set a mutually agreed upon interview date, time, and location. Four participants initially agreed to participate, with three completing the research process. At the time of the interview, the data collection procedure, and consent form were reviewed in person. Participants were informed that they could withdraw their consent at any time, refuse to answer certain questions, and take breaks as needed. A list of local

mental health supports was provided to participants alongside the consent form. When the participant indicated their readiness to begin, the researcher began recording the interview. The interview began with a review of the demographic questionnaire, which then led in to the interview questions. All interviews began with the first question from the interview protocol (see Appendix B) but followed different patterns after the first question, leaving room for flexibility and exploration as advised by Finlay (2011) and Smith and Osborn (2008). The researcher occasionally jotted down notes during the interview, and following the interview the researcher recorded notes, observations, or reflections in the research journal. Interviews took place between July and October 2016 and ranged from approximately 40 to 90 minutes in length. Once all interviews had taken place, they were transcribed verbatim. Pauses were denoted with ellipses, and any significant non-verbal behaviour (laughter, long pauses) was noted in brackets. Upon completion of the transcripts, a copy of the transcript was provided to respective participants via e-mail for reflection and feedback. One participant did not respond; one said they did not have any feedback; one provided further reflections on their experience with disability and seeking mental health support on campus. These additional comments were included in the data analysis.

Data analysis. Data analyzed consisted of interview transcripts and demographic information from three participants. IPA follows an ideographic approach to analysis, with the aim of uncovering key experiential themes (Finlay, 2011). IPA is not a prescriptive approach, and its founders urge researchers to be creative and flexible rather than try to follow a single method (Finlay, 2011). Nevertheless, Smith and Osborn (2008), Smith, Jarman, and Osborn (1999), and Smith, Flowers, and Osborn (1997) provided an outline of the steps of IPA that was used during analysis, described below:

1. Looking for themes in the first case.

The first step of IPA is similar to a free textual analysis. It involves reading the first transcript over a number of times, using the left-hand margin to take notes on anything of significance regarding what the interviewee has said. Thus, I read through the first transcript, making notes (including questions, comments, and noting potential themes) in the left-hand margin. Once this process had been completed, I read through the transcript again, this time using the right-hand margin to note emerging themes. These were derived from transcript notes and focused on a more psychological conceptualization of notable

patterns of items of significance. The aim was to use one or two words or brief phrases to “capture the essential quality of what was found in the text” (Smith & Osborn, 2008, p. 68), keeping in mind that the theme titles must still maintain a thread to the original text in the transcript.

2. Looking for connections.

Following repeated read-throughs of the first transcript and notations of emergent themes, emergent themes were listed sequentially (I began this process on paper but then moved to a word document for ease of analysis). I then looked for connections between these emergent themes. Themes that seemed to have common connections were clustered together under a separate heading representing a “superordinate theme.” Strong recurring themes were occasionally also separated as superordinate themes in and of themselves. These themes were then checked against the original transcript to maintain the integrity of the verbatim descriptions provided by the participant.

3. Listing themes

Though the literature recommends creating a table of themes, I left this step for when all three transcripts had been analyzed. Instead, I created a simple theme list, with the superordinate theme heading in bold and the sub-themes listed underneath.

4. Continuing the analysis with the second transcript

The process of free textual analysis was repeated for the second transcript, with notations made in the right-hand column. Following this, emergent themes were noted in the left-hand column, this time comparing the themes of the 2nd transcript to the list of themes from the first transcript analysis, noting similarities and differences through iterative process. Thus, the second transcript analysis made note of emergent themes common to the first transcript, as well as others that had not been noted in the first analysis.

5. Expanding the theme list

Once the second transcript had been analyzed, emergent themes were listed sequentially and cross-checked against the theme clusters (i.e., superordinate themes). Themes that were common to the first transcript were noted, and additional themes were analyzed to determine whether they fit under an existing theme cluster. Additional clusters were created for new themes, and an expanded theme list was created.

6. Continuing the analysis with the third transcript

Steps 4 and 5 were repeated with the third transcript, using the expanded theme list to check against emerging themes from the third transcript. Once the third transcript had been analyzed and themes had been listed sequentially, a drafted “Master List” was created with all theme clusters, including the cluster heading and a list of the sub-themes. Some emergent themes were dropped due to redundancy—repetition of similar themes using different wording—while others were included in existing clusters or moved to create new clusters.

7. Checking transcripts with the master list

Once a master list of theme clusters had been created, each transcript was read through again, in order, and checked against the master list. In this way, themes that had emerged in later transcript analyses were uncovered in the first or second transcript and additional emergent themes were noted.

8. Creating a table of themes

The Master List was adjusted to best reflect the verbatim descriptions and thematic clusters that emerged from the second analysis of the transcripts. Following this, a table of themes was created, listing the theme heading, the subthemes, and verbatim examples from the transcript. This table was used to create the theme table (see Table 1) and in the writing of the thematic analysis.

Quality and Trustworthiness

Credibility. Shenton (2004) describes credibility in the context of qualitative research as dealing with the question “How congruent are the findings with reality?” (p. 64). According to Shenton, using well-established research methods, reflective commentary, member checking, and peer scrutiny can all help in establishing credibility. IPA has been well-established in the literature on disability-related research, and the literature on creating interview protocols, conducting interviews, and conducting data analysis was consulted in doing this research. My research journal, as well as the use of critical reflexivity, provides reflective commentary on the data collection and interpretation. One part of member checking involves ensuring the intended meaning of the data, which was achieved by allowing participants to read over and reflect on their transcripts after their interview. Peer scrutiny was provided, in part, by my thesis supervisor, who provided feedback on both the interview transcripts and my journal throughout the data collection process.

Transferability. Transferability refers to the extent to which findings from a qualitative study may be applicable in similar contexts. Shenton (2004) and others warn against a preoccupation with transferability in qualitative research, arguing that transferability may be an unrealistic goal. However, one way to ensure transferability can be evaluated is to provide a rich description of both the context of the researcher (see Appendix C) and the phenomenon being researched, which I have described in the methodology.

Confirmability. According to Shenton (2004), confirmability requires ensuring “the work’s findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher” (p. 72). Provision of an “audit trail” or detailed description of analysis and thematic development, in addition to the use of member checking, can enhance the confirmability of a study (Shenton, 2004). The researcher’s acknowledgment of his or her own bias and reasons for choosing a particular methodology are also paramount to confirmability. The thesis includes a discussion of my pre-understandings and an explanation for the choice of methodology. In addition, I have chosen to employ critical reflexivity as a way to enhance both confirmability and transferability, as discussed in the following section.

Critical reflexivity. The concept of intersubjective meaning-making and the inevitable process and consequence of interpretation is a foundational assumption of IPA. In IPA, it is assumed that researchers will bring their subjective selves and preconceptions into the research—but they are also expected to be able to identify and reflect upon their experiences and assumptions, and how these may play a role in producing interpretations (Finlay, 2011). In her writing on phenomenology for therapist/researchers, Finlay (2011) advocates for engaging in hermeneutic reflexivity, which involves a continual reflection on our interpretations and the phenomenon being studied.

Critical reflexivity has been promoted in the feminist research literature as a way of “developing liberatory and transformative research practices that recognize and respond to power in the research process” (Pazella, Pettigrew, & Miller-Day, 2012, p. 168). Reflexivity challenges researchers to reflect upon, and respond to, power differentials and ways in which the researchers’ own social identities and relationships intersect with the research (Daley, 2010). A preliminary research reflection, written before data collection began, can be found in Appendix C. My critical reflection on the process of data collection, analysis, and interpretation can be found in Chapter Six.

CHAPTER FIVE

Results

Participant Context

Three participants were involved in this study. Table 1 below details participant characteristics. All participants were university-educated and had a minimum bachelor's degree, as well as identified as Caucasian and were Canadian-born. All participants also had experiences with more than one therapist. Reasons for not currently being in therapy included financial barriers, location barriers (living in an isolated location), and previous negative experiences resulting in hesitancy to pursue further counselling.

Table 1

Participant Characteristics

	Cameron	Diane	Chloe
Age	Early 20's	Early 40's	Early 30's
Gender	Non-binary transgender	Cisgender woman	Cisgender woman
Symptoms	Depression, anxiety, PTSD, suicidality	Depression (including post-partum), anxiety, PTSD	ADD
Diagnosis	No formal diagnosis received (self-identified)	Diagnosed with depression and anxiety in early 20's	Diagnosed with ADD in early 30's
Age of First Experience with Counselling	Adolescence	Childhood	Mid-twenties

Professional Assistance	Social worker Certified counsellor	Certified counsellor Psychologist Psychiatrist	Certified counsellor Psychologist Psychiatrist
Duration of Counselling			
shortest	1 session	2-3 sessions	1 session
longest	Several months	Several months	Several years
Reason for Termination	Limited number of sessions available Financial Dissatisfaction	Limited number of sessions available Financial Dissatisfaction	Dissatisfaction Financial Moved to new city

Thematic Categories and Themes

This study aimed to explore the phenomenological experience of counselling clients with psychological disabilities by asking “How do counselling clients with psychological disabilities construct their experiences within counselling and with counsellors through the lens of their disability experiences?” This section will explore the six major themes, and their respective subthemes, as identified in the analysis (see Table 2).

Each theme will be listed and described in turn. Included in each thematic section is a discussion of the sub-themes, including verbatim quotes from participants to bring the themes to life. It is important to understand that while these themes are explored individually, they are not strictly delineated—they are overlapping and interwoven, and each theme speaks to and informs the others.

Table 2
Themes and Subthemes

Themes	Subthemes
Embodied Difference	Symptoms Self-worth Embracing difference
Meaning and Disability	Defining disability Diagnosis
Intersections of Identity	Gender Sexuality Physical disability
Emotional Labour	Navigating the day-to-day Navigating ableism Navigating counselling
Language	Accessing language Language as a weapon
The Therapeutic Alliance	Negative experiences Positive experiences Counsellor self-disclosure

Theme 1: Embodied Difference

A recurring topic in exploring the experience of psychological disability for participants was the feeling of “difference.” Overall, participants experienced difference in both positive and negative ways, and described their experiences with psychological disability as “*usually feeling*

like an outsider,” “*struggling all the time,*” and “*[feeling] invisible.*” The theme *Embodied Difference* represents the internal, embodied experience of psychological disability, including how participants understand and experience their symptoms, the impact of symptoms on their self-worth and self-understanding, and how participants embrace difference.

Symptoms. In discussing her life before diagnosis, Chloe, who was not diagnosed with ADD until her early 30’s, states: “*I always felt like there was something wrong.*” This feeling of “wrong-ness” appeared to be embodied in the symptoms of the participants—in thoughts, feelings, or behaviours that labelled them, both to themselves and to others, as “different.” For Cameron, who struggles with self-diagnosed anxiety, depression, and PTSD, these symptoms included intrusive thoughts and difficulty sleeping:

Really intrusive thoughts. Um... barriers with like, my appetite, sleeping, um, being able to like get out of bed to go do things. Um, in high school I used to not sleep, ‘cause I knew that if I would sleep I would sleep for like fourteen hours, so I just didn’t sleep for a week and then would crash on the weekends.

Cameron also describes feeling depressed and suicidal most days, which first led them¹ to seek counselling in high school:

Before I first attempted to see a counsellor I think I attempted suicide once. And didn’t tell anyone about it [...] I was also self-harming a lot [...] I was, um, getting really drunk, sometimes, sometimes I was sober, and I was taking pills that I found in my house. So I was taking mostly painkillers, and I would also sometimes mix in like, random bottles that my mom had around... that my mom had in the kitchen. [...] I think [with the] intention of killing myself, like not sure, but like, kind of hoping for it.

For Diane, the symptoms also started young:

Anxiety for me would have begun by the time I was in grade 1 and... I mean I got... I had night terrors since I was in a crib so I remember that far back... but um, yeah, so, night terrors, also nightmares and um, just like, yeah [...] Um... so grade 1 was the beginning of anxiety yup. Say... grade six was the beginning of depression.

The symptoms of her as yet diagnosed ADD became part of Chloe’s personal history:

¹ Cameron’s pronouns are “they” and “them,” reflecting their non-binary gender. For more information, please refer to the demographics section.

I was almost expelled from high school. Because I was late for school. Or suspended. Not expelled, but suspended [...] Which like, I used to miss the bus in the morning. And as a teenager you're already self-conscious about everything. And so, and my parents would shame me and be like, come on get out of bed... kind of like the what's wrong with you but without saying that explicitly. Um. And it was to the point where the guys at the local restaurant which I had to walk by to get to the bus stop would place bets on whether or not I would make the bus in the morning and if I didn't I would... if I missed the bus... I would walk into the restaurant and someone would drive me to school.

Self-worth. Participants' experience of symptoms, as well as the impact these symptoms had on participants' lives, influenced their feelings about themselves and who they were. It became, as Diane described, *"the character... it's a character rather than an illness."* For these clients, their experience of psychological disability often seemed to become indistinguishable from their own personalities and ways of being. As Chloe describes:

ADD manifests as a lack of discipline and a lack of ability to prioritize and um, emotional impulsivity and all these symptoms that are like, would be associated with personality and I think that there's... um... there is a, you know, a problem with pathologizing personality, certainly.

As a result of viewing these differences as inherent to who they were, some participants did not perceive these symptoms to be unusual. Diane, who began experiencing symptoms of anxiety and depression at a very young age, explains: *"I didn't know this wasn't normal. I wondered how everyone else got things done with all this fear in their heads."* Chloe describes a similar difficulty in noticing her challenges:

I'd only ever lived in my own head... this is gonna sound weird... I only ever lived in my own head, so like you know I've only ever had my life experiences, so something I found really difficult, and I saw other people struggle with, but I... I saw that they didn't always struggle as much as I did.

Even when participants became aware of their symptoms as part of a psychological disability, they still struggled with the impact on their self-esteem. They describe their self-talk as riddled with self-doubt and deprecation, including feelings of being "unloveable," "alienated," and "crazy." Cameron summarizes these feelings with their description of their feeling when

they sought out counselling: *“I felt like there was something wrong with me that no one could help with.”*

Embracing difference. Despite the barriers that these differences presented, each participant also emphasized the ways in which embracing their diverse experiences have enriched their lives. Cameron detailed how their experience with the disability community helped them to see disability as an asset:

I think mostly from like, disabled organizing and being with people who like, celebrate those differences and work together as a community to support each other, rather than just pretending they're not happening [...] One thing that I've been told a lot in the last couple years is that I'm really gentle and when people tell me that I like to say “Oh it's because I'm sad, and I like... understand why gentleness is important,” so to be able to like, bring disability into the things that people appreciate about me [...] It makes me feel... like it's an asset almost. Like it's something that I have that not everyone else has and it's a way that I can bring knowledge to spaces and make them safer for other people.

Chloe describes how ADD helps her understand her strengths: *“People, like, with ADD tend to be lateral thinkers and um... we connect the dots in ways that other people don't. We have... we're really good at being creative and having lots of ideas.”*

Participants expressed both negative and positive feelings about the experience of difference. Embodying difference meant experiencing difficult symptoms, but it also meant enrichment through diversity of experience.

Theme 2: Meaning and Disability

Some of the interview questions specifically asked participants about the meaning of disability to them. Participants offered varying perspectives, but further discussion elicited a separation between how participants understood disability for themselves and how they perceived those around them to understand disability. The theme *Meaning and Disability* describes the various ways participants define disability and how they have come to find themselves within that definition, including the impact of diagnosis on this journey.

Defining disability. Cameron described disability as *“Barriers, almost. Or like, things that I have to put extra energy into to be able to live my life.”* This description of disability as being characterized by barriers is echoed by the other participants. Diane, who also uses a wheelchair as a result of a physical disability, hints at this when she describes disability by saying *“nothing*

seems very simple.” Chloe also identifies barriers in her definition of disability, describing it as “A condition that hinders one from participating in a society the way that it’s set up.” She goes on to illustrate this:

If someone’s in a wheelchair and they can’t get around... okay, maybe other people have legs that you know, can carry their weight. And this person doesn’t. Okay, maybe that means that parts of their body won’t work and aren’t able to do certain things. But... the thing that, that’s different... the thing that makes them dis-able, is that sidewalks have curbs. And that stores don’t have ramps. And that, like... they don’t leave enough room between the aisles.

Participants also came to find meaning in the word “disability” at different times in their journey with disability and in different ways. For Diane, who experienced chronic physical illness from a young age and now uses a wheelchair, recognizing her emotional suffering as a form of disability was a challenge, complicated in part by not receiving a diagnosis until later in life:

They didn’t name it this at all, but I didn’t realize I was anxious and depressed. I had no idea [...] I didn’t know this wasn’t normal. I wondered how everyone else got things done with all this fear in their heads [...] Really, I never recognized, I never considered calling anxiety or... or my own depression a disability

Chloe expresses discomfort with the term “disability,” a term that carries a lot of baggage that she tries to challenge:

I know there’s a lot of feelings around, um, mental health, and this idea... I don’t like the idea of having a condition meaning that you’re in some way defective or broken, I’m just different. Um, so I definitely identify... I joke that I identify as neurodivergent, rather than having a disability, because neurodivergent sounds more badass [...] So there’s a lot of, a lot of stigma, I think, around the word, “disability,” because I mean, quite frankly, it’s dis-able. I mean you’re not able.

Diagnosis. Despite her struggle with the language around disability, Chloe describes experiencing validation after receiving a formal diagnosis in her early 30’s, after struggling with symptoms of ADD since childhood:

It was... kind of, oddly enough, validating, and um... I’ve been doing a lot of reading since and there’s actually a book about ADD called “You mean I’m not lazy, stupid, or crazy.”

Because those are a lot of things that we're taught to think, or that we end up thinking, when we don't know that... "Oh, it's not me, I have a thing... I'm not a loser who's incompetent and incapable, I have a thing." (Laughs). Like, I have an actual condition.

Diane was also impacted by the formal diagnoses of depression and anxiety she experienced in her 20's. She describes what the process of conceptualizing anxiety and depression as diagnosable disabilities meant to her: *"What did it mean to me. I think it probably really gave me a break (laughs). Like, to realize that no amount of... trying harder was going to change how I felt I guess."*

Cameron has never received a formal diagnosis, but identifies with the term psychological disability because of symptoms they self-identified as being related to PTSD, anxiety, and depression. For Cameron, however, the meaning of disability seemed to shift after counselling:

It almost felt like something like you could like, work to fix. Which I don't know if I agree with now. But I think I remember feeling that way, like it was... like there were these tools and if I use these tools maybe one day I won't feel this way or um... or I can like hide that I'm feeling this way better [...] Now I feel like that's BS.

As the meanings of disability evolved for participants, through diagnosis, counselling, or other life experiences, participants saw their own experiences reflected in their understanding of disability. These understandings and experiences evolved, and continue to evolve, informing a mutable definition of disability with both negative and positive connotations.

Theme 3: Intersections of Identity

The theme *Intersections of Identity*, represents how other identities embodied by participants—including those related to gender, sexuality, and other types of disability—impact participants' understanding and experience of psychological disability. Participants' exploration of the meaning of their experiences with psychological disability inside and outside of the counselling room were informed by the other identities they carried. Discussions of gender/sex, sexuality, and other forms of disability peppered the interviews, and demonstrated how intersections of identity can alter the experience of both psychological disability and counselling.

Gender and sexuality. In Diane’s case, postpartum mental health issues—generally unique to women²—exacerbated her symptoms:

And so, I had my son, he was my first, and I had postpartum anxiety and major, major sleep deprivation for months. Um, to the point where I was so sleep deprived I couldn’t remember words like really basic words [...] Until the point where I would lie in bed anxious just worrying about my son all the time.

For Chloe, the experience of psychological disability was similarly impacted by being a woman:

It’s also different for like, women who have ADD, which is interesting. Um, and I hate gendering things but like, it’s a fact. It’s like a biological fact that like, a lot more women experience inattentive type, and so they end up being caught later on in life and so by the time they receive diagnosis later in life there’s already all kinds of shame and feelings and stuff to unpack. Whereas my guy friends who have ADD [...] have known since they were, you know, early teens if not children and were like, you know... stereotypically fed Ritalin or whatever at a young age, um, whereas I don’t have that many female friends... I have one female acquaintance... who has it.

Cameron, who began formally identifying as transgender and non-binary in the past few years, and who came out as bisexual in their late teens, describes how their experiences with gender are at the core of many of their struggles with psychological disability:

So one thing I’ve learned over the past few years is that I’m constantly feeling invalidated in my gender and my sexuality. Um, experiencing heteronormativity and cisnormativity everywhere. People don’t use my pronouns. Some people don’t use my name. People call me girl and woman. All the time. And I’m constantly having to remind myself that I’m valid the way I am and it takes a lot of energy. And it makes me really sad. It’s one of those things that I think if I didn’t have that layer in my life, dealing with depression would be so much easier because I think a lot of it is really rooted in feeling like I don’t belong in spaces and for a lot of people I don’t exist.

² While I use the term “women” here to refer to postpartum mental health issues for ease of reference to gender and sex-related issues with disability, I acknowledge that there are individuals who may give birth and experience postpartum mental health issues who fall outside of the gender binary or who do not identify as women.

Moreover, Cameron's gender and sexual identity complicates their ability to access appropriate care:

I never felt like I could be out to a counsellor. So even... I think [one of my counsellors] I came out as bisexual. Uh... I never came out as trans, and I think even when I came out as bisexual it was like... "Oh that's normal," like move on, like didn't wanna like... it was almost uncomfortable to like, sit on that. Um... and then [...] I went to the gender and sexuality expert and it turned into an info session so...

Cameron's difficulty in accessing care is reflected in the experience they reference above.

Describing their experience with the counsellor they were referred to specifically for issues with gender and sexuality, Cameron says:

[I] was also talking about a relationship ending recently and I was explaining how it was non-monogamous, and I talked a little bit about my gender, which is like a factor that came in a lot in the past few years, um, my sexuality... and then... we moved so far away from like, the counselling session and more into education session where she was asking me about the acronym, and [...] it was like, "Oh you're queer, tell me about all these things."

This experience was Cameron's last with counselling. Now, they are hesitant to pursue it further:

And what's stopped me from going to counselling in the last... two years even though I needed it is feeling like my counsellor won't understand the gender component (mhm) which is so important, so what's the point of putting in all that work.

Physical disability. While Diane was the only participant who experienced multiple types of disability, her experience—discussed in the previous section—is an important one to explore when examining how intersections of identity influence the experience of psychological disability. Diane's very first counselling experience, when she was young and in the hospital, reflects how her experience of physical disability—including intestinal and musculoskeletal issues—coloured her view of counselling:

[Getting] back to my room and... I don't know if this was a social worker or a psychologist but there was someone waiting in my room [...] She didn't introduce herself, I didn't know her name or who she was. And she began asking probing questions [...] It just like, made me really... I felt, I felt really enraged. Yeah. Uh, and so (laughs) so that would have been one of the negative experiences just, just you know. [...] There's no comprehension at all.

Diane's experience of physical disability also profoundly impacted her personal understanding of the meaning of disability. Diane describes her experience of psychological disability as:

Utterly separate in my head [...] Um... really, I never recognized, I never considered calling anxiety or... or my own depression a disability. I didn't recognize it as making me a person with a disability... I really didn't [...] For me it's very much like an emotional and embodied response. It doesn't always have a lot of labels. So I think actually that's made it much harder to... to sometimes get help. And I think that also, one of the interesting thing about that, that sharp delineation [...] is generally the perception.

Though Diane recognizes her experience of psychological disability, and identified with the definition in the inclusion criteria for this research, she still struggles with the concept. Diane states towards the end of the interview: *"I think I... still identify myself as being strictly, having a physical disability."*

Cameron, Chloe, and Diane each demonstrate how membership in other marginalized groups—be it gender, sex, sexuality, or non-psychological disability—can impact the experience and meaning of psychological disability, as well as perception of and access to mental health care.

Theme 4: Emotional Labour

The theme *Emotional Labour* explores the ways in which psychological disability requires work from those who embody it, including in navigating their everyday lives, their relationships with the world, and the counselling experience.

Navigating the day-to-day. Participants frequently mentioned the concept of "energy" and "work" when discussing psychological disability, both in the context of living with symptoms and in navigating relationships-including those with their counsellor. Cameron describes this in discussing the meaning of disability to them: *"...Things that I have to put extra energy in to... to be able to live my life."* Chloe also describes the extra energy psychological disability required of her day-to-day:

Yeah, I think it was really frustrating that people were just like, "Oh you're just not trying hard enough." Whereas what they don't know that 35th percentile of ability to cope with everyday life, like, "You know what? I'm actually trying eight times harder than most people just to be normal, just to function every day," which, that was a hard realization for sure.

Everyday situations take on a different meaning for participants when they must consider navigating their disability. Diane explains how a simple night out differs for her as a result of both physical and psychological disability:

I was just thinking this yesterday about classmates and the idea that we could talk about going out and for them [...] you know it was well, I mean they probably had questions about well do I have the energy to go out tonight or do I have the money, and then me realizing like, for me it was always a case of well... I... I'm already fast-forwarding to how to park, or, will I be able to get into that building, like the issues are so, they just are so compounded but, but so normalized for me that they don't even come out most of the time.

These mentions of coping, energy, and “trying eight times harder” reflect the extra labour participants must put in to keep up in a world that may not always consider their disabilities.

Navigating ableism. Participants described experiencing a range of ableist attitudes and beliefs, being both targets of these attitudes and passive observers. Diane, for example, describes a comment from a close family member after her first child was born, “He said: ‘*You shouldn't have any more children*’ ... so basically him telling us that I couldn't handle another kid.”

Cameron also describes witnessing ableist attitudes from those around them:

Usually people don't know I have a psychiatric disability without my telling them, so I've heard a lot of comments especially at work, like, either putting other people down for taking time off, or questioning the validity of them taking time off um, making fun of people with disabilities...

Chloe experienced similar attitudes in the workplace:

Um... but even then like, I was discussing how I'd tried Adderall, I was on Adderall at the time, I felt like I needed to try medication [...] I was having trouble sleeping, and my one colleague was like, well, “Why don't you just like, have you tried melatonin?” Like, have you tried this, have you tried that? People mean well, but it was like... “Oh you should just take melatonin” like that would just solve all my problems and like I have tried melatonin and it doesn't necessarily do it for me.

Chloe also describes how these workplace attitudes reflected a specific type of ableism that demanded she conform to a certain idea of how a person was supposed to be:

Um, my boss, I actually sat him down one day [...] and I said [...] I really appreciate your flexibility because mornings have always been very difficult for me my whole life. I try, but it's always been a challenge. And he's like... can't you just drink an extra coffee in the morning like everybody else? [...] Like I think that, like, my boss's comment speaks volumes 'cause it was like, can't you just take, drink another coffee like everybody else. Can't you just be like everybody else. And the answer is no I fucking can't.

While Chloe revisited experiences in the workplace, Diane described how similar attitudes permeated her academic experiences:

I mean honestly in my undergrad degree anytime a student had depression and we had to go talk to the prof that we spoke to about needing an extension we were never... we were encouraged to say we might have mono and go get tested for it. Mono was the go-to... how many times did I have to get tested for mono, oh my god (laughs).

Facing these attitudes was draining for participants, often leading them to doubt their own experiences or behaviours. Chloe describes how social attitudes at work and at home caused her to doubt herself:

Between facing so much ableism and stigma at work ... Like, there were so many people that wanted so many things from me and had so many expectations of what I should do and what behaviours I should have and I wasn't... I felt like I wasn't living up to anyone's expectations. [...] [My partner had] established social norms and structure and to the point where he actually did not want me to challenge [my workplace's] decision to let me go and by challenge I mean submit a formal grievance. Um, because he said I would be stigmatized, and, as a rabble rouser, and I would not... it would impede my ability to find further employment. [...] And amidst all of this shit storm I thought... "Oh my god, is it me? What am I doing wrong? How did I fuck up my life so badly?"

Cameron echoes this self-doubt, in their earlier statement: *"I'm constantly having to remind myself that I'm valid the way I am and it takes a lot of energy."*

Participants often struggled with balancing their desire to be seen in a positive light with their internal reaction to others' ableist behaviour. Chloe touches on the difficulties of addressing ableism in her discussion of the "tyranny of the majority":

One concept we learned in school [...] is tyranny of the majority. And that's kind of what it is. And... it's a point of privilege I think that a lot of normies don't see... forgive the

term, forgive the term, a lot of neurotypical folks and able-bodied folks don't see how some things just don't work for people. And when they... when it's pointed out to them they just feel pity. Like... they don't necessarily help. Um... so, it's a matter... it's kind of like this whole other area of privilege really.

Diane elaborates on this: *"It's their happy world that they need to exist in, I think it's... I think to certain degrees it's like extreme selfishness ... uh, um, it's also very normalized."*

Participants also described having difficulties in addressing ableist attitudes or beliefs.

Cameron describes the impacts of this challenge:

I think that it made me more aware of all... all of the shitty things that were happening and so I feel almost more exhausted [...] Wanting to say something but feeling like I couldn't when those comments were being made, and wanting to stand up for myself in the way that I saw other disabled people standing up for themselves, but feeling like it was just too much energy.

Diane frames this as a universal experience of disability in the context of socialization, stating:

I think for the past years what I've just been trying to do... is really recognize that I'm not going to be quiet about those concerns because for me and from what I've been reading a lot you know there's this expectation that um... we try to make everyone else at ease, people with disabilities try to put people without disabilities at ease, and I mean in part it's so that we can feel that we're blending in, but another aspect of it is just, this is what we've learned makes it easier to be among other people. So it's such a catch-22.

Thus, psychological disability not only requires emotional labour when managing the internal experience of symptoms or dealing with day-to-day functioning, but also demands emotional labour when navigating social situations with others, who may participate, implicitly or explicitly, in reinforcing ableism.

Navigating counselling. Emotional labour was not just something participants described outside of the counselling room. Participants also described the work required from them to participate in counselling, elucidating the emotional cost of self-exploration and vulnerability for them as counselling clients, particularly when counselling experiences are negative, rather than positive. This was most clear in Cameron's description of exploring some of the deeper issues they brought to counselling: *"[The issues] felt like they were more... like there were so many more layers to them that I would have to unpack that it felt like a lot of work."*

The emotional labour required by participants as counselling clients was particularly clear when counselling experiences were negative, rather than positive. Cameron describes their reaction after a negative session with the counsellor who derailed the session by asking questions about LGBTQ+ issues:

So frustrating. And I was like, this is not why I'm here, I already know this stuff. I'm not here to educate you, you're supposed to be supporting me [...] And what's stopped me from going to counselling in the last... two years even though I needed it is feeling like my counsellor won't understand the gender component which is so important, so what's the point of putting in all that work.

Chloe also mentions the “work” required of her in counselling, illustrating it as a barrier to effective change in her life:

With CBT I thought I would get like strategies for being on time or strategies for prioritizing my work [...] And I kind of... maybe this is really jaded, and I kind of realized I'm on my own. Because... when I talked to her about being on time, um, one of the things that I had received like way, like years before, was like a form to fill out about like (putting on a voice) “What's the task? What time is it right now? How long do I think it's going to take?” Ok, do the task, how long did it take, like, or how long do I think it took, how long did it actually take. And like, ok, methodologically that's sound, but realistically I'm not going to fucking do it, because then I'm not going to catch my bus (laughs). Like, in a realistic everyday setting, that is not helpful [...] Like and this is the thing, I want to want to get better but I also don't want things to be inconvenient and I can't afford for things to be inconvenient because I don't have the f-ing time. And so like, I don't mind doing homework in theory but if it's something that's going to interrupt my everyday when my problem is interruptions and inability to focus, that's the last thing that I need.

By contrast, Diane expresses regret over not having the ability to put more work into counselling, and that her counsellor did not either:

I think in the early years I would have liked to have [...] just have maybe more insight at the beginning, I just don't think that the... I don't... you know it's just unfortunate that the person I saw first didn't seem to have a very complicated understanding of how we could look at therapy. Um, and I certainly didn't have the skills to make it complicated.

Diane's comment reflects an awareness that counselling requires active work from the client, and that a failure or inability to do that work can result in less than optimal results in counselling.

Theme 5: Language

The theme *Language* describes the impact of language on understanding and navigating disability. The sub-theme *Accessing Language* discusses how an understanding of and access to language impacts the ability of participants to understand and express their experiences, including the impact of language in the counselling room. *Language as a weapon* will portray how participants navigate language as a way to navigate ableism, and how language can be used as an expression of humanity.

Accessing language. In discussing the meaning of physical and psychological disability in her life, Diane states:

I think in general, conversations about disability don't come into everyday discourse very easily, um, I mean we may be... as English speakers, we all speak English, but it's an able-bodied language, it doesn't embody disability, it doesn't sort of have my experience in it, and so how do you even describe your... those unique pockets of life. Well, eventually I think most people don't and... and when they do it makes people uncomfortable.

Diane touches on a theme that emerged in different ways with each participant—that of finding the words to discuss disability in a way that captured their unique experiences. Revisiting an earlier quote, Diane describes the struggle to even understand how the word “disability” could embody her experiences of depression and anxiety:

Um... really, I never recognized, I never considered calling anxiety [or] my own depression a disability. I didn't recognize it as making me a person with a disability. I really didn't [...] And I'm saying that 'cause I don't think I have the right framing or the right language for it.”

The struggle to find the words to discuss the complex experience of psychological disability presented issues in counselling, as well. For Diane, this meant that her experiences with ableism often went unexplored: “*I would have talked about those moments [of ableism] but I think it's easy to have conversations with doctors and therapists that never really go too far into what that means. And I didn't really know the word ableism.*” Cameron, too, struggled with a lack of

language that described the complex intersection of their experiences with psychological disability, gender, and sexuality:

I think probably [gender] has been a theme in the depression, but I didn't start realizing gender things until like six years ago, when I started acknowledging feelings around gender, and not even verbally, like I didn't have the language then. I didn't know trans was a thing.

Language as a weapon. The issue of language emerged not just as that of access but also as one of meaning. While participants struggled, in some ways, to find the words to describe their experiences, the words they eventually chose to describe those experiences were chosen carefully and with intent. Chloe's description of choosing the term "neurodiversity" over that of "disability" highlights the ways in which participants navigated language and meaning:

Um, so I definitely identify... I joke that I identify as neurodivergent, rather than having a disability, because neurodivergent sounds more badass (laughing) [...] I'm just, I'm very aware of the connotations of the different words, right? So, like, you and I can talk about disability like it, you know, whatever, but um... my mom, for example, and my Dad, like, when I was talking about identifying at work, about like having a... you know... requesting accommodation or maybe submitting a form for taxes [...] my Mom was like... "Don't tell people, well don't..." you know. So there's a lot of, uh, a lot of stigma, I think, around the word, uh, "disability," because I mean, quite frankly, it's dis able. I mean you're not able.

Chloe is not the only participant who negotiates language as it relates to disability. Cameron, too, chooses their words carefully, though their goal may be different:

Yeah [disability is part of my identity]. I usually identify as crazy [...] And that to me, that word feels powerful. Especially growing up I had so many partners that told me I was crazy [...] and then to reclaim that word and be like, "Yeah, I am... and? Like, you knew that before we started dating. Why is this... like just when you're mad at me that's when it comes up, so..." Um, that word feels good to me. Like no one can use it as a weapon against me. Like, yes I am.

While Chloe chooses alternative language to try to avoid the stigma of disability, Cameron embraces stigmatizing language in an effort to push back against that stigma. Diane

highlights how big an impact the language participants use to talk about themselves—and the language others use to talk about them—can have:

Language is so compulsory able-bodied that... not only are we not having the conversations we should be having on an everyday basis but... it, it influences who we... well obviously it does, it influences subjectivities, and who has humanity or more of it.

Thus, as Diane points out, while participants may use language as a weapon, language that excludes disability can also be used against them.

Theme 6: The Therapeutic Alliance

Participants described a wide range of experiences with counselling. What emerged from these discussions was the importance of the therapeutic alliance—the client’s relationship with the counsellor—and how certain characteristics and behaviours, both negative and positive, influenced that relationship.

Negative experiences. Negative experiences with counsellors was a topic for each of the participants. As previously described, Diane’s first experience with counselling, which she characterizes as “unhelpful,” occurred when she was quite young and in the hospital as a result of chronic illness:

She began asking probing questions. Do you think you’re fat? Do you like your body? Like, so she was... wondering if I had an eating disorder. [...] There’s no comprehension at all. I mean I wore long sleeves and long pants in the summer because I didn’t want people to see me, how skinny I was. So, she wouldn’t have been helpful to me.

Similarly, Cameron’s first experience with counselling left them feeling unaided:

In high school it was the suicide stuff. And that counsellor forgot our first two appointments and then in our... the one we actually had she told me that she didn’t think anything was wrong with me... because I didn’t disclose to her that I was suicidal [...] It really sucked. It made me feel like she was right... like (putting on a voice) “Oh, other people have it worse.” She used those words with me. “Other people have it worse than you, why are you here?” Um.... And it felt like I, like, couldn’t talk to anyone about it. If that was like, someone who was trained to talk about it said these things... then how could [I talk about it] to anyone. Um, yeah, it was really frustrating. [I feel] so angry [talking about it now].

Participants had negative reactions to counsellors for many reasons. As previously described, Cameron's negative experience with counselling continued with a different counsellor who focused more on their gender and sexuality than on helping them:

I forgot about her because it was one session, but I'm surprised I forgot about it because it made me so angry, that session [...] [It was] so frustrating. And I was like, "This is not why I'm here. I already know all of this stuff. I'm not here to educate you. You're supposed to be supporting me" [...] I didn't book another session [...] I knew right away I didn't like her and I didn't want to be counselled by her.

Diane describes a counsellor with whom the relationship reminded her of another, more complicated relationship in her life:

The reason I switched from one therapist or psychologist to another was, I felt like my psychologist [...] was too emotionally invested in me [...] I felt like... yeah, so... it's really funny I mean it's such a fine line but I felt like... my... things that upset me really upset her in a personal way. Not in a judgy way but in a... it felt like I was dealing with my mom, who, um, I mean as a child growing up with a disability, there is this... tendency for a parent to be really uh... overly protective. So my hurts often became her outrage but for her to be outraged meant that I... she takes over all that airspace [...] And so I felt like I'd be looking after her, and I couldn't have that with a therapist. And although... so... I didn't necessarily equate her with my mom at the time, I recognized that I wasn't comfortable with her being upset by the things I needed to talk to her about.

For Chloe, the counsellor's orientation and approach was not a good fit:

When I was talking to her about how stressed out I was about work, she was trying to like... it's basically weighing pros and cons, but she wanted me to like write it down on paper and [...] I was like, "I'm not stupid, like, I have a concept in my head of, like I... I'm capable of abstract thought. I'm capable of, I can list the pros and cons for you right now." [...] I was just like, this isn't... this is dumb, this isn't an actual strategy. Like, it's not like I'm not thinking about these things. I'm analyzing and overanalyzing all the time, I need help. I need you to tell me what to do.

Participants' negative experiences with counselling were wide-ranging but focused on the fact that, in one way or another, their needs were not being met.

Positive experiences. Participant reflections on experiences with counselling that had a positive impact on them focused on trust, empowerment, validation, and challenging perspectives, all of which contributed to a positive therapeutic alliance. Cameron reflects on how empowerment (the feeling of being in control of their own therapeutic exploration and the decisions made within the room) and validation (having their experiences and thoughts recognized and affirmed) within the counselling relationship helped to facilitate trust:

That's how I grew to like [my counsellor], actually, was when I... was talking to her about an abuse situation at home and we had to call CAS together because my sibling is... was younger at the time. Um... And then we started unpacking a lot of the stuff with my family that was making me really sad [...] I liked that she like, gave me power in the situation. So... it was funny because we were working on like anxiety and phone calls and then she let me call CAS myself. [...] I think I like trusted her after that. And I liked her. And I wanted to know more of what she thought. I was more willing to listen to her [...] And she like, really validated me.

For Diane, having a trustworthy person with whom she could be open and honest was paramount:

The relationship I've had with counselling I haven't felt like I need to make [my therapist] comfortable in any way (okay)... there were times obviously I think when, if I wasn't feeling very well, like if I was really depressed at the time, I didn't necessarily feel like I even had the energy to go and open all up at an appointment but most of the time I couldn't wait like it was my way of diffusing or... airing out.

The support Chloe's counsellor offered helped her to feel empowered, and the counsellor's validating and non-hierarchical approach (something that Chloe believed was not how counsellors are expected to behave) helped to foster trust:

But when [my counsellor] said, um, that this is our last session and she was like, "I think you're going to be ok... I'm always here for you, if you want to come back (but I think, I think you're going to be ok...)," that was really empowering [...] We were two people sharing knowledge with each other, and she was more of almost a friend, um, in that she validated my feelings, would be helpful with suggestions, and would provide guidance without in any way being like, hierarchical or condescending or judgy or... and I mean I know, I realize that's not what counsellors are supposed to be...

While validation was important for all participants, being challenged or offered alternative perspectives was also important. Chloe's counsellor provided guidance in dealing with problems that may not have a solution:

...She helped put things in perspective and um, was helpful in reminding me to um, spend energy on me and in the present (mhm) [...] she helped kind of walk me through the fact that I might never understand why or I might never... I might understand why but it might still hurt, which is the case [...] She kind of helped me make sense of where societal expectations fell short. And... that it's shitty but I'm not wrong.

Cameron's therapist offering an alternative perspective on psychological disability helped them to feel validated:

She challenged [my ideas about disability] by making it feel normal. So I felt like, there was like, this big thing that was wrong with me and no one would ever love me because I was just, struggling all the time.

Furthermore, Cameron identified being challenged as key to their positive experiences with therapy:

I liked having counsellors that would challenge me, like being challenged by a counsellor was nice. I didn't recognize it until later. Um. But I definitely think, like, that piece has helped me work through some things [...] Like the negative thoughts. And thinking they were like fact when they were... thoughts.

Participants' positive experiences were varied, but generally focused on the fostering of trust and empowerment. Through two opposing actions—validation and challenging client perspectives—counsellors were able to develop trust with clients and help them feel empowered.

Counsellor self-disclosure. Not all experiences that impacted the therapeutic alliance could be simply defined as positive or negative. Counsellor self-disclosure was discussed by all the participants, and it had both positive and negative implications. Chloe encountered several professionals who shared her diagnosis, which she expressed mixed feelings about:

...So, on one hand it was really comforting because my [Cognitive Behavioural Therapist], first of all, disclosed with me, and that was really... um... I mean, I appreciate that openness and we could talk about when...she was like, "Well these are some of the struggles I have and here's how I... you know, here's how I deal with it and different apps" and stuff [...] But um... but yeah ultimately I, I felt like she... there... this was... I'm

going to be so judgy right now. This is so bad, but there are times that I could see that she was visibly scatterbrained and getting her notes together or whatever whatever. And it's funny because like, like I do that, but you're my medical professional and like so you should have your shit together. But like... and so I would catch myself in that moment judging her or being frustrated with myself or the situation or just have to kind of like check myself and be like, hey, this is what other people do to you. Don't be a jerk.
(laughs)

Nevertheless, Chloe did feel that personal experience with ADD helped her counsellors better understand her own experiences:

...My psychiatrist also has ADD [...] And so... and it's... it just um, like, like I said I appreciate the disclosure and I appreciate like being able to... kind of really bond with the person. [...] We had some really good chats. [...] Yeah it's good to be able to kind of, know that... the person knows where you're coming from.

Cameron also expressed mixed feelings about counsellor self-disclosure, which they felt both built trust but also prevented their own authentic self-expression.

Sometimes I would just agree with [my counsellor] to agree with her. And she talked a lot. So, I felt like it was a safe place where someone could understand that I was feeling bad but I didn't actually have to talk about it sometimes, and I would almost use that as a crutch when I went to her. [...] And she would also talk a lot about her personal experiences, um... which in the beginning I found really helpful, when I was like, growing to trust her and I think by the end I was like (laughing) "Okay I'm actually not here to, like, listen to you talk about your life," so like...

Although Diane did not have experience with counsellors discussing their personal lives, as previously mentioned, a counsellor's emotional disclosure had a significant impact on the therapeutic alliance:

The reason I switched from one therapist or psychologist to another was, I felt like my psychologist that I'd been seeing there for a couple of years, two or three years, was too emotionally invested in me... how I was. I felt like... yeah, so... it's really funny I mean it's such a fine line but I felt like... my... things that upset me really upset her in a personal way [...] I felt like I'd be looking after her, and I couldn't have that with a therapist [...] I recognized that I wasn't comfortable with her being upset by the things I

needed to talk to her about [...] And it's funny because the other therapist [...] she wasn't detached. She was and she wasn't. She certainly had empathy. She had empathy but she wasn't like, going and crying for me and that was a really big relief. (laughs)

Thus, for participants, counsellor self-disclosure helped to foster trust and a feeling of being understood, but it also resulted in potentially negative effects for the therapeutic alliance and distracting from the client's own emotional experiences.

CHAPTER SIX

Summary and Discussion

Critical Reflection

I began work on this project nearly four years ago, inspired by my own experiences with mental health, my embracing of the term “disability,” and the stories I heard from those around me about their struggles to find counselling approaches that accepted and reflected their own conceptions of their mental health experiences. Thus, I began this project with many preconceived notions in terms of what I believed about psychological disability, what I believed about counselling, and what I was hoping to find.

Research, in many ways, is a process of both deepening and expanding. In visiting and re-visiting the literature on mental health and disability, I found a blank space where I was hoping to find answers. My original hope for this research was to fill that blank space—a task that is, of course, impossible for one person. My hope, now, four years later, is to simply shine light on that blank space, so that others may notice it, may see the edges of what it could touch, and begin to find ways to fill it, bit by bit.

Participant recruitment and interviewing. When I began to recruit participants, I noticed that everyone I was hearing from was a friend or an acquaintance. At first I felt concerned, worried that this was somehow a violation of boundaries or ethics. However, discussions with my supervisor, and reading the literature, led me to realize that there are both benefits and drawbacks to conducting research with participants who I already had a relationship with, and the best thing to do was simply to be aware. In many ways, I feel that my pre-developed relationship with participants was an asset, and that they were more comfortable being open and honest about their experiences—rather than being concerned about answering questions the “right way.” as I had perceived some participants to be in a previous study conducted for a research methods class—leading to richer dialogue and more authentic expression. However, I found it incredibly difficult to disentangle myself from the interview process, often feeling drawn in to offer my own perspective or experience as I normally would in conversation with a friend. Thus, the interview process emphasized to me how vital it is to be prepared not just for the participant’s stories and reactions, but also for my own. A few times, I found myself getting irritated with a perspective a participant was offering, feeling personally affronted when it clashed with my own experience or viewpoint. I used these moments as

additional insight, noting them in my research journal whenever possible, and being sure to pay attention to the meaning of the participants' words, rather than my interpretation. The transcription process was especially helpful in this regard, as I was able to listen again to the interviews, noting when I had pushed too much or not enough, and considering what participants said and how they said it.

Thematic analysis. I found thematic analysis to be both liberating and challenging. I felt a great deal of anxiety that my transcripts would yield no results, that my interview questions were not worded properly or that the interviews had gone off track and not given me enough to work with. This, of course, was not the case, and the anxiety likely came from the fact that the interviews had simply taken turns that I hadn't expected. In the end, I was glad for this, as I was able to approach thematic analysis with few preconceived notions about what I would find, knowing that the interviews had not yielded the conversations I had anticipated. In reading the transcripts, I often returned to my thesis question, reminding myself what questions I was trying to answer and looking for answers within the emerging themes. Again, there was a great deal of anxiety as it felt that the themes were random or did not fit together. However, in reading and re-reading, and in revisiting my thesis question, I found that the themes did indeed answer my question, and did indeed fit together—again, simply not in the way I was anticipating.

Results. At the time this research began, I was sure that I would discover ableism in the counselling room. It felt inevitable. It felt like ableism was everywhere, in my life, in the life of my friends, permeating the very fabric of our existence. Instead, the results painted a complex, textured picture of psychological disability in counselling—one in which participants reflected on their experiences with both frustration and hope. I found, in writing the final chapters of this thesis that many more nuances emerged. I was able to draw links between different themes, and between the themes and the literature I had been immersed in for the past four years. These links emerged organically, despite, rather than because of, my immense anxiety that my themes would yield no meaningful discussion.

I have done my best, throughout this process, to be aware of my own preconceptions, experiences, and expectations for the research. I chose to engage with interpretive phenomenological analysis because I do not believe any researcher can be truly objective, and I wished to approach research with that authentic understanding. I am relieved to say that many of

my pre-conceptions were squashed in the process of this writing, and it is my hope that the interpretation of these results remains true to the voices of the participants.

Main Findings

This section will discuss the themes and sub-themes expanded upon in Chapter Five, exploring more in-depth the meaning of these themes and how they might be interpreted. Explorations of themes will inevitably be overlapping, but I have attempted to unpack each theme in turn, in the order they were originally presented, with a separate section discussing sub-themes when necessary. Connections to the literature will be made throughout this section, highlighting when a finding is supported by pre-existing research or theory, and when it appears to be new or less represented.

Embodied difference. The embodiment of difference constituted both negative and positive experiences for participants. While symptoms were universally described as negative experiences, the learning and self-development that came about from those symptoms created an understanding of self for participants that could be seen as both helpful and harmful. Embodying difference set participants apart from those around them, making them aware that they were not like other people, even if they did not quite understand how. In some ways, this experience of embodied difference reflects the relational social model of disability (Thomas, 1999), in that it demonstrates an experience of disability and that is both internal (symptoms, personal narratives) and external (social expectations and others' responses to behaviour impacted by symptoms).

These differences also became engrained in participants' personal narratives, becoming, at times, indistinguishable from personality traits. In recounting stories about childhood, participants often discussed believing simply that that was "the way things were," whether it be constant lateness or anxiety-induced nightmares. The internalized belief that these occurrences were manifestations of a participants' character, rather than symptoms caused by a psychological disability, were only reinforced, later, by the ableist attitudes of those around them, who often seemed to imply that participants were somehow to blame for these symptoms, that if they would only "try harder," something might change. This seems reflective of Corrigan and Watson's research on the impact of mental illness stigma (2002), which indicates that one way stigma may manifest is by seeing people with mental illness as personally responsible for their experiences. This stigma may lead to self-stigma on the part of people with mental illness who are exposed to such beliefs. Marks (2002) argues that disability "comes to constitute an internalized form of

oppression which shapes the personal identities and relationships of both disabled and non-disabled people” (p. 1). In the challenge participants faced in teasing out the difference between personality and symptoms of impairment, we see the ways in which personal identity was shaped by their experience of embodied difference.

Though differences that set participants apart from their family and peers may have arisen from negative circumstances, those differences sometimes blossomed into traits, characteristics, or strengths that participants now pride themselves on. Participants seemed to draw strength from those who shared their experiences or from the wider disability community, and found positives emerging from their experiences, locating strengths specific to their diagnoses or resulting from their disability experiences.

Discussions of disability empowerment and disability pride can be found scattered throughout the literature, most often within the context of disability activism. Most notable for those with psychological disabilities is the Mad Pride movement, founded in Toronto as a part of the consumer/survivor/ex-patient model in the early 90’s (the first mad pride march was called “Psychiatric Survivor Pride”) (Haigh, 2016). Though such movements have existed for decades, current research featuring positive perspectives of disability, particularly from those with disabilities themselves, is still rare. Of note, however, is Olkin’s (2011) discussion of the rise of disability community and culture and disability pride in the context of Disability-Affirmative Therapy. Olkin highlights the need for therapists to be aware of these movements, and the resources and support they may offer clients. Thus, an awareness of the Mad Pride movement could be an important resource for counsellors working with clients with psychological disabilities.

Meaning and disability. The idea of disability as barriers was one that emerged strongly throughout the interviews and analysis. Consistent with the social model of disability (Beresford, Nettle & Perring, 2010; Mulvany, 2000; Reeve, 2004), participants described how society is structured in ways that refuse to consider, or actively exclude, them. Psychological disabilities are often considered to be “invisible”—so too, often, are the barriers that come with them. This can present a problem for those attempting to articulate barriers or ask for change. A “simple” description of barriers often reverts to the physical, as demonstrated by Chloe’s quote describing physical barriers to illustrate how society is structured for those who are non-disabled, at the expense of those with disabilities. Yet participants enumerated numerous barriers for those with

psychological disabilities, whether or not they conceptualized them as such. Whether it be the structure and required hours of an average workday, the requirement to be at one's desk from 9 to 5, deadlines in school or at work, or assumptions and misinformation about mental illness, these barriers, while not physical, are nonetheless very real. This is consistent with the theorists who conceptualize both structural barriers—such as inflexible deadlines—as well as relational ones as part of the psycho-emotional dimensions of ableism: how ableism operates on psychological and emotional levels to undermine the well-being of people with disabilities (Beresford & Swartz, 2008; Reeve, 2004). Thus, the feeling that to be disabled in society meant encountering barriers to living life “normally”—whether those barriers were internal or external—was not only a repeated theme in this study, but one that occurs time and again in the literature on the experiences of people with disabilities.

Intersectionality. The intersections of numerous social locations with psychological disability represented a particularly complex topic. In many ways, this research only scratched the surface: an exploration of intersectional identities in counselling could certainly constitute its own research project, and this project included only a small sample that did not include any ethnic, racial, or religious minority clients. Nevertheless, from the interviews that did take place, one might argue that intersections of identity represented one of the biggest challenges for clients when it came to seeking therapeutic help. In this study, the two main intersections revealed were that of gender and physical disability.

Gender. The challenge facing Chloe, as an adult woman seeking a diagnosis for ADD—a diagnosis that is generally assigned in childhood, and in majority, to boys—points to the gendered way in which both professionals and society at large view certain diagnoses. Consistent with research that demonstrates that gender influences both diagnosis and treatment of ADD—as well as the experience of the disorder itself, particularly in adulthood—Chloe's gender presented a barrier to accessing appropriate care because of preconceptions held by both herself and others about what ADD looks like and who it impacts (Williamson & Charlotte, 2015). The issue of gender is even further complicated for Cameron, whose gender in and of itself can still be considered a disorder according to the DSM. Cameron acknowledges that their gender identity is tied into their experiences with depression, but maintains that it is the devaluation of their gender that contributes to the depression—rather than, as some clinicians might argue, the depression contributing to Cameron's conception of gender. This complicated relationship between gender

identity and mental health for transgender counselling clients is reflected in the literature on the topic, which highlights that while transgender clients' mental health issues may exist outside of their gender, mental health issues among transgender clients may also be the result of discrimination (Hunt, 2014). Fears of discrimination permeate the experiences of transgender counselling clients: Research shows that transgender individuals name fear of judgement or discrimination as their main barrier to seeking counselling (Hunt, 2014). This is consistent with Cameron's report that their main barrier to accessing mental health care is concern about finding a counsellor who will be able to work with them within the context of their gender identity. It is also interesting to note that, unlike the other two interviewees, Cameron had not received a formal mental health diagnosis, despite having perhaps some of the most severe symptoms, including substance abuse and suicidality. While no direct relationship can be drawn between Cameron's gender identity and their lack of diagnosis, it is certainly worth mentioning that diagnoses can seem particularly dangerous to those whose sense of self continues to be pathologized by clinicians (Hunt, 2014; Holley, Stromwall & Bashor, 2012; Nelson, 2006). While a client being transgender, in the eyes of some clinicians, might complicate the mental health landscape, for the client, being transgender complicates their ability to access safe, supportive mental health care.

Physical disability. Diane's experience with chronic illness and physical disability had a profound impact on her experience of psychological disability. Her first experience with a counsellor was within the context of being young and living with chronic illness, and many of her triggers with regards to depression and anxiety can be traced back to her experiences with physical disability. In addition, Diane's understanding of disability in a purely physical sense eclipsed, for many years, an understanding of psychological disability. Despite her descriptions of depression and anxiety starting in early childhood and creating challenges throughout her life, Diane describes physical and psychological disability as being "utterly separate" in her head, and states she still sees herself as purely physically disabled. The experience of multiple types of disability, then, is clearly a complex one, and one that impacts, in profound ways, a client's beliefs about disability. Diane's interview made it clear that, for her, the challenges of physical disability always came first—that the barriers of being in a wheelchair exceeded, in many ways, the more private barriers that her depression and anxiety created. While research on the experiences of individuals living with both physical and psychological disabilities is scarce, a

study by Grewel et al. (2002) seems to confirm that other individuals with disabilities feel similarly to Diane: Study participants with impairments often did not identify as disabled because they strongly believed that disability involved a permanent, physical impairment that affected mobility. According to Reeve (2004), this “hierarchy of impairments” (p. 92) can be traced back to the way society has traditionally divided people with disabilities by impairment group—an approach that distinctly lacks intersectionality. Thus, while the tendency to view impairments as hierarchical certainly may not be universal for all individuals who experience both physical and psychological disability, it highlights how different the two experiences are and the importance of understanding the nuances and complexities of them as separate experiences, though they may share common elements.

Emotional labour. The term “emotional labour” is defined as “the labour involved in dealing with other peoples’ feelings, a core component of which is the regulation of emotions” (James, 1989). Emotional labour was a strong theme that encompassed internal and external experiences, both within and outside of the counselling room. It is also the theme that perhaps came the closest to reflecting the theoretical framework for this project, the concept of psycho-emotional ableism.

Ableism. “Psycho-emotional ableism” refers to the way ableism operates on psychological and emotional levels to undermine the well-being of people with disabilities (Watermeyer, 2014). Navigating ableism was one part of the emotional labour performed by participants, and one that often caused a great deal of emotional pain. Participants most often mentioned ableism that occurred within their family, workplaces, or schools. These are locations within which most of us spend a great deal of our time, and that have a great significance to many of us. This ableism was reflected in attitudes and beliefs expressed by family members, loved ones, bosses, colleagues, teachers, and peers, as well as larger institutions. None of the ableist remarks described by participants were direct attacks on them. Rather, they were often couched in expressions of concern, pieces of advice, or criticisms of others with psychological disabilities based on misconceptions. Theorists refer to these types of incidents as microaggressions, and research has shown that such incidents, unsurprisingly, cause distress (Olkin, 2011). The remarks described by participants reflected attitudes that psychological disability was not legitimate or valid, that identifying as psychologically disabled reflected a weak character or a desire to shirk responsibility, that being disabled meant that a person could

not or should not do certain things, and that to identify as disabled was to label oneself as a “target” or to “rabble-rouse.”

Navigating this ableism was draining for participants, and often made them question their abilities, their realities, or their decisions. Yet not one participant described an instance in which they “fought back.” In fact, some participants seemed, at moments, to express understanding for the perspective of those who expressed those ableist beliefs, particularly when it came to their loved ones. Others simply expressed the feeling that to fight back was too much work, or exhausting. Thus, the majority of the labour performed when it came to navigating ableism consisted of “keeping the peace” by repressing the emotional pain that arose in the face of ableist comments. Some theorists may conceptualize this as “internalized oppression,” arguing that experiences of ableism result in self-censorship and emotional repression (Reeve, 2006; Watermeyer & Swartz, 2008). Watermeyer & Swartz (2008) put forward that, as a result of socialization and internalized ableism, often people with disabilities are unable to clearly recognize their own oppression. Whether the choice to “keep the peace” arose from internalized ableism or something else, it is clear that navigating ableism required a great deal of energy from participants.

Emotional labour in counselling. None of the participants expressed experiencing ableism within the counselling room. Nevertheless, they all expressed that counselling was “work.” First, the simple act of emotional exploration and expression had a cost for clients. Participants expressed an awareness that this exploration and expression required time and energy, and that it was not always easy. Adding to this was the risk of emotional exploration with someone who was, in many ways, a stranger. As counselling clients, participants were required to put an immense amount of trust into the counsellors meant to help them, and when this help did not always meet their expectations—or indeed, disappointed them completely—they were often left feeling that they had paid an unfair price. Sometimes this was because a counsellor failed to understand what a client was feeling. Sometimes it was because a client did not feel engaged with the help a counsellor was offering, or felt that the counsellor was simply unhelpful. Occasionally, participants expressed a feeling that they had to “take care” of their counsellor by listening to them discuss their own experiences. For clients, this meant limiting their own emotional experience and expression.

Participants also described having to educate counsellors about their own intersectional identity (gender, sexuality, or physical disability), highlighting how intersectional identities may increase the burden when it comes to emotional labour for these clients. In these instances, participants expressed a feeling that counselling was “too much work” or “not worth it.” In essence, the “cost” of their own emotional expression or labour was not worth the reward that these counselling experiences offered.

Interestingly, little research is available that conceptualizes counselling as emotional labour for the client—though quite a bit can be found in the way of emotional labour as an unspoken part of the job for mental health professionals. This may be, in part, because it is assumed that emotional labour is an inevitable part of participating in counselling. It may also be, however, that clients with psychological disabilities are more likely to feel the need to repress their emotions or emotional expression, resulting in more emotional work. Indeed, a key argument with regards to psycho-emotional aspects of disability is the socialization of people with disabilities to repress their authentic experiences in favour of comforting the non-disabled people around them (Reeve, 2002; Watermeyer & Swartz, 2008). Watermeyer and Swartz (2008, p. 60) state:

Social interaction always requires the selecting out of parts of ourselves, but in order to be socially appropriate disabled people may have to hide or manage reactions to aspects of their lives and experiences which are always with them. Many interactions disabled people have may be preceded by a conscious anticipation of what may be required to manage others’ emotionally laden (though perhaps disguised) reactions to impairment. Thus, while it is certainly true that counselling requires emotional work on the part of the clients, it may be that participants were more conscious of the need to manage both their own emotional expression and the reactions of their counsellors as a result of previous experiences of psycho-emotional ableism.

Language. Language represented, in a way, another barrier for those with psychological disabilities. As reviewed in the literature, the numerous ways available to talk about psychological disability, and the implications associated with those words, create complicated paths for participants to navigate (Price, 2013). For Diane, Cameron, and Chloe, language was inherently connected to the meaning of disability, and the simple act of naming their experiences—whether through diagnosis, counselling, or personal reflection—represented an

important step in defining their experiences. Participants often avoided labelling their experiences as “disability.” This is consistent with research that shows that over half of a group of people with impairments who were surveyed did not identify as disabled (Grewal et al, 2002).

Diane struggled to see how the term “disability” could include both her experiences of chronic illness and physical disability as well as her experiences with depression and anxiety. As previously mentioned, Diane’s struggle is reflected in Grewel et al.’s research (2002), which found that participants with impairments often did not identify as disabled because they strongly believed that disability involved a permanent and visible physical impairment that affected mobility. Reeve (2004) highlights that coming to view one’s impairment as a disability is often as a result of others’ perceptions of one’s impairment (for instance, receiving disability benefits from the government). These findings highlight the challenges of those with invisible disabilities to be seen as “legitimate,” both by themselves and by others.

Chloe recognized the negative association with the term “disability” and attempted to circumnavigate it by using other language, such as “neurodivergent.” In this avoidance of the term, we see the power the word “disabled” holds, and the limitations that are placed upon it in terms of representing only certain experiences and meanings. For these participants, identifying as disabled required expanding the meaning of the word to represent more than visible, physical disabilities, and to mean something beyond the negative connotations the word holds. Nevertheless, participants indicate that there are ways to reclaim language, and to redefine the meaning of words. For Cameron, this is illustrated by their use of the word “crazy” to describe their experiences, a deliberate reclamation of a word that has been used against them (and historically, against both those living with mental illness and those who are marginalized by society, including women and trans people).

In their interviews, participants describe how disability means barriers, yet the negative connotation participants held with disability was in the way the term is perceived as referring to a person’s lack of ability. Rather than reflecting participants’ own understanding of the word disability, this connotation of disability meaning “less able” seemed to come from the world around participants, rather than from their own experiences. Jeffs (1998), drawing on feminist theory, emphasizes that language and naming have immense power, and compares the reclamation of the words “mad” and “crazy” to the lesbian and gay movements of the 70’s and 80’s, which reclaimed words like “dyke” and “queer.” The reclamation of these words, she

argues, are a push back against silence and shame, a “celebration of the experience that most people look down upon with denigration” (p. 37). The meaning the research participants have created themselves around the word disability has expanded to include, reframe, and celebrate their own experiences, whether or not it is a word they use to describe those experiences publicly.

The therapeutic alliance. It should perhaps not be surprising that the issues the participants struggled with in counselling are those described by many other counselling clients in many other studies: their relationship with their counsellor, and the feelings of trust, validation, and empowerment the counselling relationship did or did not foster. Participants valued therapists who encouraged authentic expression, who offered alternative perspectives, and who honoured clients’ own knowledge and expertise. Perhaps most pertinent was participants’ indications that they desired concrete explorations of ableism in counselling. For Diane, ableism was not named or explored in counselling, and although she felt she benefitted from counselling overall, she indicated that exploring issues of disability was made difficult by the counsellor’s lack of knowledge and not explicitly naming ableism as a cause of distress. For Chloe, exploring the ableism she experienced—at work, from her family, and in her relationship—allowed her to come to terms with some of the ways she embodied difference, and to come to terms, too, with the fact that she might always be seen as different. Previous research with clients with disabilities has shown that clients appreciate counsellors who have specific knowledge about disability (Hunt et al., 2006), and Marks (2002) has argued that counsellors must move beyond the fear of politicizing counselling in order to properly empower and advocate for counselling clients. Thus, though the participants rarely described explicitly exploring issues of disability in counselling—it was rarely named as such, and, save for Chloe, certainly not explored as a contributing factor to distress—there was certainly a desire for such an exploration.

That exploration could, perhaps, be facilitated by counsellors with their own personal experience with psychological disability. In keeping with previous literature on the topic, participants indicated mixed feelings about counsellor self-disclosure (Audet & Everall, 2010; Henretty & Levitt, 2010). Navigating counsellor self-disclosure was often difficult and uncomfortable for participants. Nevertheless, the interviews seem to suggest that participants felt comfortable with and reassured by professionals who had personal experience with psychological disability. This is validated by previous research with mental health service users

that shows that many individuals with psychological disabilities have a positive attitude towards—and even a specific desire to work with—mental health professionals who have their own experiences with mental illness (Beresford, Nettle, & Perrin, 2010). Nevertheless, it is important for counsellors to attend to their decision process, including their intentions, of disclosing about their own psychological disability, and the consequences—whether intended or unintended—on clients when such disclosures occur (Kottsieper, 2009).

Limitations

This research explored the experiences of individuals with psychological disabilities in utilizing counselling services. Due to the qualitative nature of this research, all experiences and voices were certainly not represented, and as such the findings represent only a snapshot of the complex and varied meaning of psychological disability for counselling clients. As only three participants were included in this research, the group lacks heterogeneity. Of note, men and people of color were not represented in these interviews, and, due to their social locations, their perspectives could differ in many ways from those of the participants included in this research. Participants were also required to identify as living with a psychological disability, which may have excluded participants who meet the criteria for psychological disability but do not identify with the term. In addition, participants were required to have attended a minimum number of sessions and to not currently be attending counselling, excluding participants who may have attended only one session (perhaps due to poor experiences) or who might still be in counselling. Finally, due to the nature of the recruitment method, all participants were acquaintances of the researcher, and were aware of the researcher's own self-identification with psychological disability. It is certainly possible that such knowledge may have impacted the way participants responded, whether to the benefit or the detriment of the research.

Implications for Research, Practice, and Training

The phenomenological focus of this study gives voice to the experiences of counselling clients with disabilities. In this chapter, I have offered interpretations of the results that highlight how clients understand and experience psychological disability and counselling, while offering perspectives on these meanings through a relational social model of disability and within the current research landscape. These findings offer insight into further research, practice, and training in counselling clients with psychological disabilities.

The concept of mental illness as disability is still relatively new, and still remains partially sequestered within the domain of critical disability studies. The results of this research indicate that some counselling clients with mental health issues perceive themselves to be disabled as a result of societal barriers. Further exploration of mental illness using critical disability theory could shed light on how counselling clients experience impairment and disability within the context of mental health issues, and the impact of these aforementioned societal barriers on their experiences and well-being.

Participants indicated that their intersectional identities, particularly in the context of gender and non-psychological disability, impacted their experiences of both psychological disability and counselling. Intersections of identity give way to experiences and oppressions that can impact individual mental health. It can also impact access to, and experiences with, mental health services. Further research on intersectional identities within the context of counselling could explore the experience of multiple social locations within the context of counselling. In particular, exploring the intersecting identities of physical disability and gender could provide a deeper and more nuanced understanding of how these identities impact the experience of psychological disability. Research elevating client voices may further illuminate these experiences and provide insight into how clients with intersecting identities can be better supported. Indeed, the need for further research on client perspectives—both clients with disabilities in general, and psychological disabilities in particular—cannot be overestimated. The literature provides a great deal of theory, as well as many perspectives from service providers and family members. Yet perspectives from clients themselves are often lacking, and without elevating the voices of clients, counselling research cannot truly speak to how best to approach these complex issues.

Participants indicated that they valued counselling and that, in general, their experiences were free from overt or covert ableism. Nevertheless, the theme of emotional labour emerged strongly in this research, both within and outside the context of the counselling room. Exploring ableism from an emotional labour framework may provide an expanded understanding of the psycho-emotional dimensions of disability, as well as provide insight into the unique emotional experiences of counselling clients with psychological disabilities. Similarly, further exploring the meaning and consequences of the psycho-emotional dimensions of disability within the counselling room could help counsellors become aware of the complex emotional and relational

processes that impact clients with psychological disabilities. This phenomenon may also not be unique to clients with psychological disabilities, and further exploration of the concept within the general counselling domain could also provide meaningful insight into client perspectives and potential barriers to success in counselling.

Concerns about the lack of awareness and emphasis of the impacts of ableism emphasize the need for more training for counsellors on the topic of disability. Though the finding that more training is needed is not revolutionary—the first chapter of this thesis emphasized just this issue in the context of graduate counselling programs—the perspectives provided by clients indicate that a need is certainly present. Olkin's Disability-Affirmative Therapy (D-AT) provides one such model for educating counsellors about disability, and provides a framework for counsellors working with clients with disabilities that emphasizes client perspectives. Exploring the application of this model with clients with psychological disabilities could provide much needed evidence-based recommendations for practice.

Final Remarks

In the context of disability research, people with disabilities have often been the subject-object, but not the beneficiary, of disability research. The voices of people with disabilities, and people with psychological disabilities—whether they identify as mentally ill, disabled, consumer/survivor/ex-patient, or none of the above—are still scarce within the research literature, though they continue to grow stronger. Though this research does not provide many answers to the complicated question of supporting individuals with psychological disabilities, it is my deepest hope that it has shed some light on future questions to be answered. The social justice movement within counselling cannot, and must not, move forward without considering the implications of mental illness and disability.

References

- Adebimpe, V. R. (1981). Overview: White norms and psychiatric diagnosis of Black patients. *American Journal of Psychiatry*, 138(3), 279-285. doi: 10.1176/ajp.138.3.279
- American Counselling Association. (2011). ACA in the news: ACA expresses DSM-5 concerns to the American Psychiatric Association. Retrieved from <http://www.counselling.org/PressRoom/NewsReleases.aspx?AGuid=315a280b-4d0b-48af-9421-1f7d3f01b4b7>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association. doi: 10.1176/appi.books.9780890425596
- Audet, C., & Everall, R. (2010). Therapist self-disclosure and the therapeutic relationship: A phenomenological study from the client perspective. *British Journal of Guidance and Counselling*, 38, 327-42. doi: 10.1080/03069885.2010.482450
- Barnartt, S. N., & Altman, B. M. (Eds.). (2013). *Disability and intersecting statuses*. Bingley, UK: Emerald Group.
- Beresford, P. (2000). What have madness and psychiatric system survivors got to do with disability and disability studies? *Disability & Society*, 15(1), 167-172. doi: 10.1080/09687590025838
- Beresford, P., Nettle, M., & Perring, R. (2010). Towards a social model of madness and distress. *Exploring What Service Users Say*. York: Joseph Rowntree Foundation.
- Campbell, F. A. K. (2008). Exploring internalized ableism using critical race theory. *Disability & Society*, 23(2), 151-162. doi: 10.1080/09687590701841190
- Canadian Psychiatric Association. Mental Illness and Work. Retrieved from <https://ww1.cpa-apc.org/MIAW/pamphlets/Work.asp>
- Centre for Addiction and Mental Health (CAMH) (2012). Mental illness and addictions: Facts and statistics. Retrieved from http://www.camh.ca/en/hospital/about_camh/newsroom/for_reporters/Pages/addictionmentalhealthstatistics.aspx.
- Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist*, 64(3), 170-180. doi: 10.1037/a0014564

- Cornish, J. E., Gorgens, K. A., & Monson, S. P. (2008). Toward ethical practice with people who have disabilities. *Professional Psychology: Research and Practice, 39*(5), 488-491. doi: 10.1037/a0013092
- Corrigan, P., & Watson, A. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry, 1*(1), 16-20. PMID:16946807
- Coursey, R. D., Keller, A. B., & Farrell, E. W. (1995). Individual psychotherapy and persons with serious mental illness: The clients' perspective. *Schizophrenia Bulletin, 21*(2), 283-301. doi: 10.1093/schbul/21.2.283
- Dahl, C.M., & Boss, P. (2005). The use of phenomenology for family therapy research: The search for meaning. In Sprenkle, D., & Piercy, F. (Eds.). *Research Methods in Family Therapy* (2nd ed.) (pp. 63-82). New York, NY: Guilford Press.
- Eriksen, K., & Kress, E. (2006). The DSM and professional counselling identity: Bridging the gap. *Journal of Mental Health Counselling, 28*(3), 202-217. doi: 10.17744/mehc.28.3.4f39a6wr1n3fceb2
- Finlay, L. (2011) *Phenomenology for therapists: Researching the lived world*. Sussex, UK: Wiley-Blackwell.
- Foley-Nicpon, M., & Lee, S. (2012). Disability research in counselling psychology journals: A 20-year content analysis. *Journal of Counselling Psychology, 59*(3), 392-398. doi: 10.1037/a0028743
- Goodley, D., Hughes, B., & Davis, L. (2012). Introducing disability and social theory. In D. Goodley, B. Hughes, & L. Davis, (Eds.). *Disability and social theory: New developments and directions*. London, UK: Palgrave Macmillan.
- Grewal, I., Joy, S., Lewis, J., Swales, K. & Woodfield, K. (2002). *Disabled for Life? Attitudes Towards, and Experiences of Disability in Britain*. Leeds, UK: Corporate Document Services.
- Haigh, S. (2016). "Mad Pride France": Disability, mental distress, and citizenship. *Journal of Literary & Cultural Disability Studies, 10*(2), 191-206.
- Henkelman, J., & Paulson, B. (2006). The client as expert: Researching hindering experiences in counselling. *Counselling Psychology Quarterly, 19*(2), 139-150. doi: <http://dx.doi.org/10.1080/09515070600788303>

- Henretty, J., & Levitt, H. (2010). The role of therapist self-disclosure in psychotherapy: A qualitative review. *Clinical Psychology Review, 30*(1), 63–77. doi: 10.1016/j.cpr.2009.09.004
- Hodgetts, A., and Wright, J. (2007). Researching clients' experiences: A review of qualitative studies. *Clinical Psychology & Psychotherapy, 14*(3), 157-163. doi: 10.1002/cpp.527
- Holley, L. C., Stromwall, L. K., & Bashor, K. E. (2012). Reconceptualizing stigma: Toward a critical anti-oppression paradigm. *Stigma Research and Action, 2*(2). doi: 10.5463/SRA.v1i1.9
- Hunt, B., Matthews, C., Milson, A., & Lammel, J. (2006). Lesbians with physical disabilities: A qualitative study of their experiences with counselling. *Journal of Counselling & Development, 84*, 163-173. doi: 10.1002/j.1556-6678.2006.tb00392.x
- Hunt, J. (2014). An initial study of transgender people's experiences of seeking and receiving counselling or psychotherapy in the UK. *Counselling and Psychotherapy Research, 14*(4), 288-296.
- James, N. (1989). Emotional labour: Skill and work in the social regulation of skill and work. *The Social Work Review, 37*(1), 15-42. doi: 10.1111/j.1467-954X.1989.tb00019.x
- Jeffs, S. (1998). Madness, language and reclaiming meaning. *AQ: Australian Quarterly, 70*(3), 36-38. doi: 10.2307/20637737
- Johnson, C. (2011). Disabling barriers in the person-centered counselling relationship. *Person-Centered & Experiential Psychotherapies, 10*(4), 260-273. doi: 10.1080/14779757.2011.626627
- Kafle, N. P. (2011). Hermeneutic phenomenological research method simplified. *Bodhi: An Interdisciplinary Journal, 5*, 181-200.
- Knight, M. T., Wykes, T., & Hayward, P. (2003). 'People don't understand': An investigation of stigma in schizophrenia using Interpretative Phenomenological Analysis (IPA). *Journal of Mental Health, 12*(3), 209-222. doi: 10.1080/0963823031000118203
- Kottsieper, P. (2009). Experiential knowledge of serious mental health problems: One clinician and academic's perspective. *Journal of Humanistic Psychology, 49*(2), 174–192. doi: 10.1177/0022167808327749

- Larkin, M., & Thompson, A. R. (2012). Interpretive phenomenological analysis in mental health and psychotherapy research. In D. Harper & A. R. Thompson (Eds.). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. New York, NY: Wiley. doi: 10.1002/9781119973249.ch8
- Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretive phenomenological analysis. *Qualitative Research in Psychology*, 3(2), 102-120. doi: 10.1191/1478088706qp062oa
- Lauber, C., Nordt, C., Braunschweig, C., & Rössler, W. (2006). Do mental health professionals stigmatize their patients? *Acta Psychiatrica Scandinavica*, 113(429), 51-59. doi: 10.1111/j.1600-0447.2005.00718.x
- Lester, H., & Tritter, J. (2005). Listen to my madness: Understanding the experiences of people with serious mental illness. *Sociology of Health & Illness*, 27(5), 649-669. doi: 10.1111/j.1467-9566.2005.00460.x
- Lindseth, A., & Norberg, A. (2004). A phenomenological hermeneutical method for researching lived experience. *Scandinavian Journal of Caring Sciences*, 18, 145-153. doi: 10.1111/j.1471-6712.2004.00258.x
- Marks, D. (2002). Introduction: Counselling, therapy, and emancipatory praxis. *Disability Studies Quarterly*, 22(3), 1-5. doi: 10.18061/dsq.v22i3.355
- Mental Health Commission of Canada (2013). *Why investing in mental health will contribute to Canada's economic prosperity and to the sustainability of our health system: Background – Key Facts*. Retrieved from <http://www.mentalhealthcommission.ca/English/node/742>
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674. doi: 10.1037/0033-2909.129.5.674
- Mulvany, J. (2000). Disability, impairment, or illness? The relevance of the social model of disability to the study of mental disorder. *Sociology of Health & Illness*, 22(5), 582-601. doi: 10.1111/1467-9566.00221
- Mulveen, R., & Hepworth, J. (2006). An interpretive phenomenological analysis of participation in a pro-anorexia internet site and its relationship with disordered eating. *Journal of Health Psychology*, 11(2), 283-296. doi: 10.1177/1359105306061187

- Nelson, C. A. (2006). Of eggshells and thin-skulls: a consideration of racism-related mental illness impacting Black women. *International Journal of Law and Psychiatry*, 29(2), 112-136. doi: 10.1016/j.ijlp.2004.03.012
- Olkin, R. (2011). Disability: A primer for therapists. In E. M. Altmaier & J. C. Hansen. (Eds.). *The Oxford Handbook of Counselling Psychology* (pp. 461-479). Oxford, UK: Oxford University Press.
- Olkin, R., & Pledger, C. (2003). Can disability studies and psychology join hands? *American Psychologist*, 58(4), 296-304. doi: 10.1037/0003-066X.58.4.296
- Patton, M.Q. 2002. *Qualitative research and evaluation methods*. (3rd ed.). Thousand Oaks, CA: Sage.
- Pazella, A., Pettigrew, J., & Miller-Day, M. (2012). Researching the researcher-as-instrument: An exercise in interviewer self-reflexivity. *Qualitative Research*, 12(2), 165-185. doi: 10.1177/1468794111422107
- Pearson, C., Janz, T., & Ali, J. (2013). Mental and substance abuse disorders in Canada. *Health at a Glance*. Statistics Canada Catalogue no. 82-624-X.
- Poole, J. M., Jivray, T., Arslanian, A., Bellows, K., Chiasson, S., Hakimy, H., Pasini, J., & Reid, J. (2012). Sanism, 'mental health', and social work/education: A review and call to action. *Intersectionalities: A Global Journal of Social Work Analysis, Polity, and Practice*, 1, 20-36. Retrieved from <http://journals.library.mun.ca/ojs/index.php/IJ/article/view/348>
- Price, M. (2013). Defining mental disability. In L.J. Davis (Ed.). *Disability Studies Reader* (4th ed.) (pp. 291-307). Florence, KY: Routledge.
- Prilleltensky, O. (2009). Critical psychology and disability studies: Critiquing the mainstream, critiquing the critique. In Fox, D., Prilleltensky, I., & Austin, S. (Eds.). *Critical psychology: An introduction* (2nd ed.) (pp. 250 – 266). Thousand Oaks, CA: Sage.
- Rao, H., Mahadevappa, H., Pillay, P., Sessay, M., Abraham, A., & Luty, J. (2009). A study of stigmatized attitudes towards people with mental health problems among health professionals. *Journal of Psychiatric and Mental Health Nursing*, 16, 279–284. doi: 10.1111/j.1365-2850.2008.01369.x

- Reeve, D. (2002). Negotiating psycho-emotional dimensions of disability and their influence on identity constructions. *Disability & Society, 17*(5), 493-508. doi: 10.1080/09687590220148487
- Reeve, D. (2004). Psycho-emotional dimensions of disability and the social model. In C. Barnes & G. Mercer (Eds.). *Implementing the social model of disability: Theory and research* (pp. 83-100). Leeds: The Disability Press.
- Reeve, D. (2006) Towards a psychology of disability: The emotional effects of living in a disabling society. In D. Goodley & R. Lawthom (Eds.). *Disability and psychology: Critical introductions and reflections* (pp. 94-107). London: Palgrave. doi: 10.1007/978-1-137-12098-4_7
- Russo, J., & Beresford, P. (2015). Between exclusion and colonization: seeking a place for mad people's knowledge in academia. *Disability & Society, 30*(1), 153-157. doi: 10.1080/09687599.2014.957925
- Shenton, A. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*, 63-75. doi: 10.3233/EFI-2004-22201
- Shinebourne, P., & Smith, J. A. (2009). Alcohol and the self: An interpretative phenomenological analysis of the experience of addiction and its impact on the sense of self and identity. *Addiction Research & Theory, 17*(2), 152-167. doi: 10.1080/16066350802245650
- Smith, J. A., Flowers, P., & Osborn, M. (1997). Interpretative phenomenological analysis and the psychology of health and illness. In L. Yardley (Ed.). *Material Discourses of Health and Illness* (pp. 68-91). New York, NY: Routledge.
- Smith, J. A., Jarman, M., & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray & K. Chamberlain (Eds.). *Qualitative Health Psychology* (pp. 219-240). Thousand Oaks, CA: Sage.
- Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J.A. Smith (Ed.). *Qualitative Psychology: A Practical Guide to Research Methods* (2nd Ed.) (pp. 53-80). London, UK: Sage.
- Statistics Canada. (2012). Disability in Canada: Initial findings from the Canadian Survey on Disability. Catalogue no. 89-654-X.

- Thomas, C. (1999). *Female forms: Experiencing and understanding disability*. Buckingham, UK: Open University Press.
- Thomas, C. (2001). Feminism and disability: The theoretical and political significance of the personal and experiential. In Barton, L. (Ed.). *Disability, Politics, and the Struggle for Change*. New York, NY: Routledge.
- Tierney, S. (2002). Anorexia: Illuminating impairment or dishonourable disability? *Disability Studies Quarterly*, 22(3), 6-20. doi: 10.18061/dsq.v22i3.356
- Wahl, O. F. (1999). Mental health consumers' experience of stigma. *Schizophrenia Bulletin*, 25(3), 467-478. doi: 10.1093/oxfordjournals.schbul.a033394
- Wang, P. S., Demler, O., & Kessler, R. C. (2002). Adequacy of treatment for serious mental illness in the United States. *American Journal of Public Health*, 92(1), 92-98. doi: 10.2105/AJPH.92.1.92
- Watermeyer, B., & Swartz, L. (2008). Conceptualising the psycho-emotional aspects of disability and impairment: The distortion of personal and psychic boundaries. *Disability & Society*, 23(6), 599-610. doi: 10.1080/09687590802328477
- Watermeyer, B. (2009). Claiming loss in disability. *Disability & Society*, 24(1), 91-102. doi: 10.1080/09687590802535717
- Watermeyer, B. (2012). Is it possible to create a politically engaged, contextual psychology of disability? *Disability & Society*, 27(2), 161-174. doi: 10.1080/09687599.2011.644928
- Williamson, D., & Johnston, C. (2015). Gender differences in adults with attention-deficit/hyperactivity disorder: A narrative review. *Clinical Psychology Review*, 40, 15-27.
- Willig, C., & Billin, A. (2012). Interpretive phenomenological analysis in mental health and psychotherapy research. In D. Harper & A. R. Thompson (Eds.). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. (117-130). New York, NY: Wiley.

Appendix A
Demographic Questionnaire

1. What is your current age?

2. What is your gender?

3. Please describe your ethnic background.

4. What is your current occupation?

6. What psychological disability/disabilities do you live with?

7. Have you received a formal diagnosis for your disability/disabilities? If so, what type of professional were you diagnosed by? (e.g., doctor, psychiatrist, psychologist...)

8. At what age did you begin attending counselling?

9. For approximately how long did you see your counsellor? (If you have seen more than one counsellor please list the duration of each counselling relationship separately).

Appendix B

Interview Protocol

The main research question is: *How do counselling clients with psychological disabilities construct their experiences within counselling and with counsellors through the lens of their disability experiences?*

Before Counselling: Perceptions of Psychological Disability & Counselling

1. Can you tell me about your experience with your psychological disability up until you started counselling?
2. What does disability mean to you?
3. What do you think disability means to the people around you? How has this been communicated to you?
4. What made you decide to go to counselling? (goals, main problem)
5. What were your expectations about counselling before you began? (assumptions/hopes/fears)
6. How did you anticipate the counsellor would deal with the topic of your disability?

During: The Counselling Process

1. Please tell me the story of you first discussed your disability with your counsellor?
2. How did you help your counsellor understand your experience with disability?
(metaphors/stories?)
3. How did you feel about how your counsellor responded to your disability?
4. How do you think your counsellor's response to your disability impacted your counselling relationship? How did it make you feel about the counsellor? About yourself?
4. What did you and your counsellor do to work on the issues you brought to counselling?
(approaches/interventions)

After: Perceptions of Counselling & Disability

1. Please describe how you feel, overall, about your experience with counselling?
2. What parts of yourself were you able to reveal in counselling? What parts of yourself do you feel you might have held back?

3. How did you feel about disability after counselling?
4. If you had a magic wand you could wave such that your counselling experience could be just the way you wanted it, what would that look like? What would your counsellor have said or done?

Appendix C

Preliminary Reflexive Position

van Manen (1990) encourages researchers to engage with a topic that seriously interests them, an “abiding concern” (p. 31). Psychological disability has certainly been an abiding concern in my own life because of my personal experience with it. As someone who has been diagnosed with and treated for mental illness and who identifies as having a psychological disability, the exploration of mental illness as disability has played a crucial role in my identity development. Whereas my original introduction to mental illness was through medicalized psychology practices and texts, a search to better understand my own experience led me to engage with consumer-driven perspectives based on the principles of the psychiatric consumer/survivor/ex-patient (c/s/x) movement. These perspectives offered an alternative way for me to understand my experiences: That mental illness (or “neurodivergence”) is a naturally occurring variation in the human psychological experience, something that comes with its own benefits and challenges, and not necessarily something to be “cured” or “fixed.” In addition, many c/s/x theorists argue that our society is structured to both create negative mental health outcomes and oppress those who experience them. This was my introduction to the social model of disability, and I found it both disturbing and empowering.

I chose to engage with the topic of psychological disability within counselling not only because of my personal experience with psychological disability, but also because of the continued exclusion of disability and mental health as a topic of engagement in both academic and activist communities. Among activists and academics oriented towards social justice, discussion of intersectionality and sites of oppression are a continued focus. Despite this, disability is rarely a topic of engagement when it comes to activist discussions, and I have both personally felt and witnessed others who acutely feel this exclusion. Similarly, within multicultural and social-justice oriented counselling, disability remains a forethought, and discussion of invisible or complex impairments—such as mental illness—rarely, if ever, occurs. The lack of discussion about disability, and the (intentional and unintentional) refusal of these communities to engage with mental illness as a disability, led me to explore psychological disability from the perspective of researcher.

It is inevitable that I come to this research with preconceived notions about psychological disability, particularly due to my personal experience with the topic. My own position on the experience of psychological disability is one that takes into account both the inherent impairing effects of disability (such as physical or psychic pain) as well as the barriers that our society has constructed that create disabling circumstances for individuals with psychological disabilities. In addition, I believe that engaging with clients with psychological disabilities requires an understanding of the multiple perspectives clients may hold about disability (for instance, medical vs. social models) and working with the client from his or her own perspective. I also believe that the majority of our society holds sanist beliefs about mental illness (whether conscious or unconscious), and that these beliefs inevitably impact the intra- and inter-personal experiences of people with psychological disabilities.

I chose to conduct this research from the perspective of the client, rather than the practitioner, because of the overall lack of perspectives of individuals with disabilities in counselling research. As has been previously discussed, c/s/x community members have criticized researchers for using research with individuals with psychological disabilities to advance their own agendas and assumptions, or have eclipsed the voices and experiences of psychologically disabled clients in favour of the perspectives of family or service providers. My main hope for this research, then, is that it will give a voice to the study participants, one that will hopefully help raise consciousness about the experiences of this population and generate discussion about how we can best serve these individuals as counselling practitioners and researchers.

Appendix D

Social Media Recruitment Text

Psychological Disability and Counselling – Participant Recruitment

Are you, or is someone you know, an individual with a psychological disability who has participated in counselling?

I am recruiting volunteers for a study on the experiences of individuals living with psychological disability/disabilities who have engaged the services of a counsellor.

I am looking for participants:

- Who identify as having a psychological disability (a formal diagnosis is NOT required)
- Who have had a minimum of three one-on-one personal counselling sessions with a Canadian Certified Counsellor (CCC) within the last five years

AND

- Who attended counselling for the purpose of discussing an issue or issues related to their psychological disability

If you are interested in participating in this study, please contact myself (Alyssa) via email at



Please share this post. Please respect and protect the confidentiality of those who may wish to participate in the study by NOT tagging anyone in this post.

Appendix E

Study Description for Participants

This is to invite you to participate in a research project I am conducting for my Masters degree in Educational Counselling at the University of Ottawa. This research project focuses on the experiences of individuals with psychological disabilities in utilizing counselling services.

To participate in this research, you must meet the following criteria:

- Identify as having a psychological disability (defined, for the purpose of this study, as “Significant clinical patterns of behaviour or emotions associated with some level of distress, [suffering], or impairment in one or more areas of functioning: school, work, social and family interactions.”)
- Have sought counselling for the purpose of discussing an issue or issues related to your psychological disability
Have attended a minimum of three sessions with a Canadian Certified Counsellor within the last 5 years

If you agree to participate, you will be invited to an interview session of approximately 60 to 90 minutes to share with me your experiences with counselling. It is anticipated that this research project will be of benefit to researchers, counselling practitioners, and individuals with psychological disabilities who utilize counselling services to better understand how individuals with psychological disabilities experience counselling.

If you agree to participate, the interview will be arranged at a location and time that is convenient for you. The interview will be conducted in-person. If an in-person interview is not

possible, we will conduct the interview over Skype or other video conferencing tool. The interview will take approximately one hour. With your consent (and parental consent for participants under the age of 18), the interview will be audio-recorded to help me access the interview discussion for transcription and data analysis. If you agree to participate, you will also be provided with a copy of your interview transcript after the interview to ensure that your experiences are accurately depicted and to allow you to provide any additional reflection on your experience. You will be asked to provide transcription reflection in writing.

Your participation is completely voluntary. All information will be kept strictly confidential and you can withdraw from the study at any time without penalty. If you decide you no longer want to participate in the study, all information obtained from you will be destroyed.

This interview may require you to discuss sensitive topics, including your personal experience with psychological disability. All participants will be provided with a list of support resources they may contact should any issues arise during the interview that they wish to discuss further. If you would like to participate in this study or have any questions, please feel free to contact me, Alyssa Max, amax057@uottawa.ca or my supervisor Dr. Cristelle Audet at cristelle.audet@uottawa.ca

Respectfully,

Alyssa Max

Appendix F

Participant Recruitment Text

Department of Educational Counselling, University of Ottawa

Participants Needed for Research in Counselling

Dear _____,

I am writing because you have expressed an interest in participating in my Master's thesis research. I am currently recruiting volunteers to participate in a study on the experiences of individuals with psychological disabilities who have attended personal counselling. Your decision to participate is 100% voluntary and, should you decide to participate, you may withdraw from the study at any time. A maximum of 6 participants will be recruited for this study and participants are being recruited on a first-come, first-serve basis.

In this email, I have also attached a 'Description of the Study' for you to view to learn more about the project. Please feel free to review this and ask any questions that might help you decide if you would like to participate. If you agree to participate, you will be invited to a face-to-face interview session with me to share your experience with counselling. The interview will be arranged at a time that is mutually convenient and will take approximately 1 hour.

For more information regarding this study, or to participate in this study please contact me [REDACTED] or email: amax057@uottawa.ca or my supervisor, Dr. Cristelle Audet at [REDACTED] or caudet@uottawa.ca

Thank you,

Alyssa Max

Appendix G
Eligibility Checklist

1. Do you self-identify as living with a psychological disability? (Defined as: “Significant clinical patterns of behaviour or emotions associated with some level of distress, [suffering], or impairment in one or more areas of functioning (school, work, social and family interactions). At the root of this impairment are symptoms of biological, psychological or behavioural dysfunction, or a combination of these.” (OHRC, 2002)

2. Have you had one-on-one counselling sessions with one Canadian Certified Counsellor during which the main focus was an issue related to your psychological disability?

3. How many sessions did you have with this counsellor? (Minimum three; Preference given to longer counselling relationships)

4. Did these sessions take place in the last five years?

5. Are you over the age of 18 and able to participate in an English-language interview with the researcher?

Appendix H

Consent Form for Study Participants



Université d'Ottawa | University of Ottawa
 Faculté d'éducation | Faculty of Education

Project Title: The Experiences of Individuals with Psychological Disabilities in Attending Counselling

Names of researchers and contact information

Alyssa Max, MA student

Dr. Cristelle Audet, Ph.D.

Principal Investigator

Thesis Supervisor

Faculty of Education

Faculty of Education

University of Ottawa

University of Ottawa

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Invitation to Participate: I am invited to participate in the abovementioned master's research study conducted by Alyssa Max, under the supervision of Dr. Cristelle Audet.

Purpose of the Study: The purpose of the study is to to deepen our understanding of the experience of counselling from the perspective of individuals with psychological disabilities. My participation in this study will be of benefit to researchers, practitioners, and counselling clients to enhance understanding of how individuals with psychological disabilities experience counselling.

Participation: If I agree to participate in this study, the following will occur:

1. I will engage in an interview lasting approximately 1 to 1.5 hours about my counselling experiences. The interview will take place at a mutually chosen time and venue that ensures my comfort, safety and confidentiality. I am free to share as much or as little as I want, and to refuse to answer any question. I will be asked to choose a pseudonym for the study. Alyssa will audio-record and transcribe my interview.
2. Alyssa will contact me via my preferred method of contact (e-mail or phone) for a follow-up opportunity to review the transcript and I will have the opportunity to provide feedback and reflection on the transcript over the phone or via e-mail.

Assessment of risks: There are some possible risks from participating in this study. Talking about my experiences in counselling, especially if they were negative ones, may make me feel uncomfortable or upset. I am free to refuse to answer any questions or to stop the interview at any time. I can inform Alyssa of my discomfort at which time she will provide me with a list of resources for support services in my community for my consideration.

Benefits: I will have the opportunity to voice my experiences in counselling to contribute to the understanding of the counselling experiences of individuals with psychological disabilities, with the intent of ultimately improving counselling services.

Confidentiality and anonymity: I have received assurance from the researcher that the information I share will remain strictly confidential. My identity, or that of any person that I mention, will be known only to the researcher and will not be revealed at any time. I can choose a pseudonym for the study in order to remain anonymous. My pseudonym will be used in the interview transcripts, thesis manuscript and future publications. Any details in the interview recordings that can identify me will also be changed during transcribing. Quotes may be used by the researcher, but no information that can identify me will appear in them. Lastly, only the researcher and her thesis supervisor will have access to the interview recordings and transcripts.

Conservation of data: I have been assured that the demographic questionnaire, audio-recording, and transcript will go in a locked cabinet in the supervisor's locked office. The data will be securely safeguarded for a minimum of five years; and when research is complete, all material data will be shredded and electronic data will be erased.

Voluntary Participation: I am under no obligation to participate and, if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions without suffering any negative consequences. If I choose to withdraw, data gathered until the time of withdrawal will be destroyed. It is important to note, that while published data cannot be withdrawn, I can always request that my data (e.g., audio-recordings, transcripts) be destroyed.

I understand that information obtained from the interview and in correspondence with me will be used by the researcher for the sole purpose of this research. I acknowledge that the results of this study may be disseminated through conferences and publications, and that once the results are published there is no way the researcher can remove information related to me.

Acceptance: I-agree to participate in the above research study conducted by Alyssa Max as part of her master's thesis requirements, at the Faculty of Education, University of Ottawa under the supervision of Dr. Cristelle Audet.

If I have any questions I may contact the researcher or her thesis supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research Ethics and Integrity, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5 Tel.: (613) 562-5387 Email: ethics@uottawa.ca