Dissertations - ALL   **SURFACE**

June 2017

AN EMERGING THEORY OF PERCEIVED DISABILITY COUNSELING COMPETENCE: A QUALITATIVE INVESTIGATION OF LICENSED PROFESSIONAL COUNSELORS

Michele Rivas
Syracuse University

Follow this and additional works at: https://surface.syr.edu/etd

Abstract

Clients with disabilities engage in counseling services in a variety of settings. Given the counseling profession's emphasis in social responsiveness to multicultural issues and social justice, professional counselors are equipped with training and clinical experience that prepare them to meet these clients' counseling needs. The counseling literature highlights the pervasive absence of disability across counselor curriculum and the training paucities in counselor preparation to work with clients with disabilities. This qualitative study utilized the grounded theory tradition to illuminate the categories, properties, and dimensions involved in licensed professional counselors' perceptions of their development of disability counseling competence. This study involved a sample of twenty licensed professional counselors who graduated from CACREP-accredited programs and who had clients with disabilities by the time of the study. Participants' perceptions of their development of disability counseling competence accounted for a core category of Evolving Commitments to their role of professional counselors and to their diverse clients. This central category explained further analytic themes related to the therapeutic work, connection to the community, and the impact of systemic dimensions in the clinical practice. Several measures were taken in order to ensure trustworthiness and credibility of the results. Implications for counselor training programs, clinical supervisors, clinical practice, and professional organizations are discussed along with future research recommendations.

AN EMERGING THEORY OF PERCEIVED DISABILITY COUNSELING COMPETENCE:
A QUALITATIVE INVESTIGATION OF LICENSED PROFESSIONAL COUNSELORS

By

Michele Rivas, MS, NCC

B.S. in Psychology, Universidad Central de Venezuela, 2006
M.S. in Clinical Mental Health Counseling, Long Island University, 2013
C.A.S in Disability Studies, Syracuse University, 2017

Dissertation

Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy (PhD)
in Counseling and Counselor Education

Syracuse University
June, 2017

This is dedicated to the best person I know: Jose Gregorio.

Table of Contents

List of Illustrative Materials

Chapter I: Introduction

Introduction

In the American mental health system, counseling is a profession that is rooted in humanistic values of wellness, prevention, and development. Since the emergence of counseling as a profession in the early twentieth century, most scholars have continuously identified and addressed growth areas within the profession (Foster, 2012). Professional counseling continues to progress although, not-necessarily in a linear fashion as it asserts its foundational goals and identity (Davidson & Chan, 2014; Kaplan & Gladding, 2011).

The counseling profession has grown over the past few decades to recognize new guiding forces that constitute its core values and afford counselors with opportunities for intervention. Multiculturalism and social justice have been defined as inseparable and necessary conditions in the counseling work with marginalized communities (Ratts & Pedersen, 2014). Multiculturalism is understood as the inclusion of all the unique dimensions that shape human identity, whereas social justice, is understood as the intentional and systematic approach to disrupt oppression and achieve equity for all clients (Ratts & Pedersen, 2014). Multiculturalism and social justice are professional core values that inform training, research, and clinical practice of counselors in America (Ratts, 2009). Moreover, Chang, Hays, and Milliken (2009) stress the counseling profession's emphasis on multiculturalism and social justice advocacy as commitments aimed at counteracting the violence of oppression and inequality that impact the mental health of marginalized communities. There are prolific examples in counseling research and professional literature that underscore how groups defined as marginalized communities are more vulnerable to developing mental health issues (Chang et al., 2009).

Furthermore, multicultural frameworks within the counseling profession are progressively embracing the intersection of cultural identities and the dynamics of power, privilege, and oppression that impact the counseling relationship (Ratts & Pedersen, 2014). The field's multicultural competencies have been defined in terms of counselor self-awareness, client worldview, counseling relationship, and advocacy interventions (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). Therefore, the profession has been intentional in strengthening its multicultural core and emphasis on social justice to recognize and celebrate diversity (Hill, 2003). This intentionality has also accentuated the professional responsibility for advancement in multiculturalism to counteract counselor's bias and inequalities in the access to counseling that impact marginalized communities.

The multicultural emphasis in counselor training mainly relates to issues of race, gender, and class (Pieterse, Evans, Risner-Butner, Collins, & Mason, 2009), thereby placing less emphasis on disability and other minority issues in counseling professional practice, program admission and retention, and counselor preparation (Shin, Smith, Goodrich, & LaRosa, 2011; Smart & Smart, 2006). By 2010, people with disabilities were considered the largest minority group in the US, representing approximately 18.7 percent of the overall population (Brault, 2012; Drum, McClain, Horner, Johnson, & Taitano, 2011). From the total adult disabled population in 2010, approximately 35 percent report experiencing mental health difficulties in combination with other physical, sensory, learning, and communication disabilities that significantly impacted their daily functioning (Brault, 2012). Hence, there is a critical need to respond to the mandate of multicultural commitments of the profession by understanding practicing counselors' development and enactment of disability competence.

Given the fabric of intersecting identities represented in the population of individuals with disabilities, the counseling needs of disabled clients are likewise varied and complex. Licensed professional counselors providing services in the community are professionally responsible to ethically and effectively respond to and further advocate for the mental health needs of clients with disabilities (Lofaro, 1982; Smart & Smart, 2006; Smith, Foley & Chaney, 2008). Therefore, it is important to examine and understand the qualitative processes that emerge in the development of disability competence as counselors have achieved some years of licensed practice.

Multicultural Commitments within the Counseling Profession

Multiculturalism within the counseling profession has evolved across time and crystallized in multiple ways. For instance, given the emphasis on inclusion and equitable services for marginalized communities, the Association for Multicultural Counseling and Development (AMCD) was established in 1972 and assumed leadership to promote the recognition and representation of culture, ethnicity, race, and other social identities in the profession. Such efforts by AMCD recognized that these social identities are indelible dimensions of mental health (Arredondo & Toporek, 2004, Ratts & Pedersen, 2014). Multiculturalism has been positioned as a driving force within the counseling profession (Pedersen, 1991; Pieterse et al., 2009), legitimizing the intention for social responsibility and appreciation of diversity within counseling (Hill, 2003; Pieterse et al., 2009). By situating multiculturalism as a core force within counselor identity, the profession seeks to respond to the historical marginalization of individuals based on their ethnic, racial, cultural, and socioeconomic differences (Arredondo & Toporek, 2004). Also, by defining and operationalizing a set of multicultural competencies (Arredondo & Toporek, 2004), the

profession has sought to enhance the understanding and embracing of individual complexities within counselor preparation (Arredondo et al., 1996).

The counseling literature concerning multiculturalism emphasizes two major themes. First, minority identities are overrepresented in the utilization of mental health services (US Department of Health and Human Services [USDHHS] 2001). Chang et al. (2009) and Erevelles (2011) contended that these increased needs of minority groups correspond to the socio-historical conditions that define their possibilities for wellness and development. Further, Chang et al. (2009) emphasized the need for preparing competent counselors to professionally respond to the needs of minority clients.

Second, the professional literature highlights the inequalities in access and utilization of services by marginalized communities. Given the complex interplay of cultural, attitudinal, and language variables of minoritized groups, counseling services may not be seen as trustworthy or suitable to meet their needs (Carpenter-Song, Chu, Drake, Ritsema, Smith, & Alverson, 2010; Mills & Fernando, 2014; Safran et al., 2009; USDHHS, 2001). Therefore, it becomes apparent and urgent for the counseling profession to integrate and foster multiculturalism as a professional competency aimed to address the issues in the access and representation of marginalized communities in the promotion of counseling services (Arredondo & Toporek, 2004; Hays, 2008; Hill, 2003; Pedersen, 1991; Ratts & Pedersen, 2014).

Likewise, the multicultural discourse in counseling has evolved to embrace competencies aimed at creating social change and highlighting the critical examination of identities' interplay and transactions of power in the counseling relationship (Ratts & Pedersen, 2014). The shift towards intersectional conceptualizations of identity in counseling has fostered the emergence of models aimed to amplify the clients' lived experiences defined by their intersecting identities,

and have afforded new grounds of opportunity for a more complex understanding of identity (Singh & Sim Chun, 2010). Enhanced conceptualizations of identity offer opportunities for re-examining disability as a cultural identity and diversifying the representation of identities within the counseling profession.

Disability within the Multicultural Discourse

Even though the multicultural framework within counseling addresses issues of power, privilege, and oppression, disability as a cultural identity is rarely addressed in the multicultural counseling discourse (Olkin & Pledger, 2003; Reeve, 2000; Smart & Smart, 2006; Smith et al., 2008; Swain, Griffiths, & French, 2006). Professional standards, research, and curriculum that portray all encompassing characterizations of multiculturalism in counseling have situated disability as an aspect of identity that would require specific knowledge, awareness, and skills. Thus, disability has not been widely recognized as a multicultural concern by counselor educators and practitioners (Smith et al., 2008). Additionally, even though disability is reflected in the curriculum as an aspect of multiculturalism by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), some authors have documented the lack of emphasis on and integration of disability as a cultural identity or socio-political group within the multicultural discourse and training standards (Reeve, 2000; Smart & Smart, 2006; Smith et al., 2008).

From the overall 2014 US population who experienced mental illness symptoms, approximately 20 percent did not receive any form of mental health or substance abuse service (SAMHSA, 2014). Moreover, people with disabilities also might experience a variety of mental distress experiences (i.e., depression, anxiety, substance use) that impact their daily functioning. Mental health counselors are in a unique position to ensure the engagement of these clients in

mental health services. Moreover, given the wide array of populations mental health counselors work with, counselors can strive for equity in service delivery across all identities disability intersects with.

Furthermore, the lack of emphasis and socio-political focus on disability issues in counselor preparation manifests in multiple ways within the practice of counselors. For instance, given the lack of emphasis in disability issues in counselor preparation, the mental health needs of people with disabilities can be misinterpreted by the counselor who is responding exclusively to the disability identity (Smart & Smart, 2006). Also, counselors might under-estimate the social impact of disability, thereby overly-amplifying the influence of disability in all areas of the client's life. Counselors may also essentialize disability reducing it to grief for the presumed loss of ability and pathologizing clients' lived experience (Reeve, 2000, 2006; Smart & Smart, 2006; Swain et al., 2006). Therefore, the lack of emphasis on disability in multicultural training has significant implications for the counseling work (Olkin & Pledger, 2003; Parkinson, 2006; Reeve, 2000; Smart & Smart, 2006) and highlights the importance of attending to these issues in the practice of licensed professional counselors.

Despite the documented lack of preparation and competence in the specific identity of disability (Olkin & Pledger, 2003; Reeve, 2000, 2006; Smart & Smart, 2006; Smith et al., 2008; Swain et al., 2006), professional counselors are equipped with broad multicultural competencies that place them in a position to create change, engage, and serve a variety of populations through the work in community clinics, private practice, and other contexts (Ratts & Pedersen, 2014). The professional efforts for instilling these broad multicultural competencies in trainees represent important opportunities for the further application to and development of disability competence.

For instance, as a disabled scholar who has accessed counseling services, Reeve (2006) highlighted the importance for counselors to address the psycho-emotional effects of living in a society that represents pervasive and institutionalized barriers for individuals with disabilities and amplified the emotional dimensions of disability that relate to isolation, rejection, and discrimination. Additionally, Smart and Smart (2006) stressed the need for counselors to use their multicultural awareness, knowledge, and skills to engage clients with disabilities. These authors further emphasized the need for counselors to be aware of the service needs of these clients in order to develop and deliver equitable counseling services (Smart & Smart, 2006), and also the need to attract more disabled people to the profession (Olkin & Pledger, 2003).

In summary, the profession's grounding in multicultural and social justice commitments represents important opportunities for counselors to attend to the psycho-emotional dimensions of disability (Reeve, 2000) and translate multicultural competencies in the engagement of clients with disabilities (Smart & Smart, 2006). Moreover, multicultural professional commitments create opportunities to disrupt the lack of emphasis on disability in multicultural education and afford the examination of the processes, conditions, and dimensions that explain the development of disability competence in licensed professional counselors.

Significance of the Study

In the United States, the unequal access and utilization of counseling services has received increased national attention since 1990 given the rising numbers of mental health disorders present in the general population (Safran et al., 2009). However, the examination of these disparities at the private and government level have failed to fully examine the social and cultural variables that explain such differences (Chang et al., 2009). Safran et al. (2009) described the potential influence of social determinants "such as employment, income, housing,

and so on, which can influence mental health and access to care" (p. 1963) and called for research intended to examine the influence of social aspects of lived experiences on the incidence of and access to mental health care.

Mental health inequalities in access and utilization of services have been documented in the literature (Chang, Crethar, & Ratts, 2010; Chang et al., 2009; USDHHS, 2001). The counseling profession has actively worked to respond to these inequalities through the preparation of counselors and the establishment of professional practice standards that strive for multicultural sensitivity and responsiveness. For instance, the 2015 Multicultural and Social Justice Counseling Competencies (Ratts et al., 2016) endorsed by AMCD established a set of guidelines for counselors to enhance counseling theory, practice, and research by highlighting intersecting aspects of cultural identity. Furthermore, multicultural competencies afford counselors the possibility to recognize and address dynamic forces related to power, privilege, and oppression that impact the counseling relationship (Ratts et al., 2016).

CACREP (2016) has outlined standards to guide the training and professionalization of counselors by setting core dispositions that encompass social and cultural diversity training. However, training programs and accreditation standards have fallen short in recognizing disability as an identity that represents a complex variety of social, historical, and political implications for clients, in its intersection with other social markers (Drum et al., 2011; Pieterse et al., 2009). Clients with disabilities experience a variety of mental health needs, and professional counselors need to be prepared and competent to address and meet the specific needs of this population (Smart & Smart, 2006; Smith et al., 2008).

Disability has been minimally integrated as an aspect of multiculturalism (Smart & Smart, 2006; Smith et al., 2008). For instance, disability has been included as a single lecture

within multicultural courses (Pieterse et al., 2009). Moreover, the development of multicultural competence has been assumed to cover disability as an aspect of human variation. However, disability has been an aspect of diversity that has received less emphasis within the multicultural discourse and less attention in curricular experiences for many counselor trainees (Reeve, 2000; Smart & Smart, 2006; Smith et al., 2008).

It is estimated that people with disabilities represent the largest minority (56.7 million) in the US (Brault, 2012) and that these individuals are still engaging in counseling services every day (Smart & Smart, 2006; SAMHSA, 2014). This study illuminated how professional counselors develop the competence to work with this population and further offered implications to inform the training of future counselors from the perspective of the service providers only. In this sense, its main significance related to bringing to the foreground disability as a cultural identity in multiculturalism within counselor training. Specifically, the knowledge emerged from this study could help practicing counselors and counselor educators move beyond assumptions of all-encompassing multicultural competence to more grounded conceptualizations of disability competence as part of multiculturalism. Findings from this study may also inform the delivery of disability content across counselor curriculum.

Lastly, the main body of multicultural competence research has concentrated on the training of counselors, yet little is known about the further development or enactment of these competencies in the clinical practice of graduated counselors (Dodson, 2013; Moss, Gibson, & Dollarhide, 2014). Given that disability competence has not been studied in practicing mental health counselors, it was critical to address this gap in the counseling literature in order to inform and enhance the training of mental health counselors to engage clients with disabilities. The development of multicultural competence has been examined in practicing school counselors

(Dodson, 2013); however, the specific processes of disability competence development had not been addressed in licensed mental health counselors. Hence, it was important to examine and understand the interplay and complexity of processes that underlie and inform the development of disability competence that can explain licensed professional counselors' engagement of clients with disabilities. Finally, the understanding of these processes in licensed professional counselors can further inform advocacy initiatives at the institutional level for multicultural professional identity and funding of post-training opportunities in local community clinics.

Purpose of the Study and Research Questions

The purpose of this study was to explore the perspectives of licensed professional counselors in order to understand the process of development of their disability competence through clinical practice. For this purpose, this study used qualitative inquiry, specifically grounded theory (Corbin & Strauss, 2015) to investigate professional counselors' experiences in developing disability competence. Corbin and Strauss (2015) and Hays and Singh (2012) explained that qualitative inquiry entails the collection and interpretation of data about a phenomenon in context, which is focused on the qualities of the constructs, processes, and meanings built by the participants from different angles. Thus, this study used qualitative inquiry as it afforded the opportunity to explore the intricacies of this phenomenon and describe the individual processes that occurred within the participants' experiences.

Holcomb-McCoy and Day-Vines (2004) stressed the importance of the exploration of multicultural development and competence among professional school counselors though qualitative methodology. Vereen, Hill, and McNeal (2008) further asserted that qualitative inquiry allows the researcher to explore the multifaceted components and processes of engaging diverse clients in clinical experiences. These scholars underscore the importance of qualitative

research on multicultural development related to disability competence, as qualitative inquiry affords rich descriptions of participants' experiences about complex, simultaneous, and multidimensional processes emerging in their clinical practice. Thus, this study examined the process by which licensed professional counselors' developed disability competence through the qualitative co-construction of a theory grounded in participants' descriptions of the phenomenon of disability competence.

Even though the main purpose of this study focused on understanding the participants' experiences related to the development of disability competence, Corbin and Strauss (2015) and Andersen and Hill-Collins (2004) stressed the importance of examining individual's experiences, but also recognizing the contextual factors and cultural identities that inform these experiences. Given that the development of disability competence does not happen in a vacuum, this study sought to construct a grounded theory that embraced some cultural factors present in the counselor and the counseling relationship. Thus, this study sought to understand how professional counselors develop disability competence while being informed by their variety of intersecting identities, such as race, gender, affection orientation, disability, and class. Moreover, as a bilingual researcher of color, I was interested in complexifying the emerging descriptions and analysis by highlighting cultural and language-related factors in the memoing and journaling process. I then intentionally integrated these language and other cultural factors as part of my analysis of participant data.

According to Corbin and Strauss (2015), grounded theory allows for the identification of general concepts, theoretical explanations, and the illumination of new insights into a variety of experiences and phenomena. Further, grounded theory affords the co-construction of a theory grounded upon the lived experiences of participants. Grounded theory integrates theory, clinical

practice, and social and cultural contexts specific to the participants in ways that few other approaches can assert (Fassinger, 2005). The guiding research questions for this qualitative study were:

1) How do licensed professional counselors develop competence to work with clients with disabilities?

2) What does disability competence look like in terms of counselors' self descriptions of practice? And,

3) What are the similarities and differences of disability competence compared to multicultural competence?

This study sought to highlight the realities of professional practice of licensed counselors and their development of competence to work with clients with disabilities. The construction of disability competence is partial inasmuch as it did not include the personal accounts of clients with disabilities who use these counseling services to navigate mental distress while facing the effects of living in a disabling society (Reeve, 2000). The historical exclusion of people with disability's input in policy making (Charlton, 1998), scientific research (Olkin & Pledger, 2003), and other cultural dimensions of everyday life, has perpetuated further conditions of "poverty, isolation, indignity, and dependence [and has represented] a major human rights catastrophe" (Charlton, 1998, p. ix). In this sense, this study sought to describe the experiences and processes occurring on the counselors who provide services, and did not attempt to theorize about people with disabilities' lives as these accounts only pertain to them. Further work needs to be done to amplify disabled people's experiences and perspectives of disability competence as it relates to clinical practice.

The participants in this study included twenty (20) licensed professional counselors who had a counseling relationship with at least one client with an identified disability at the time of the study. Participants must have held a counseling license for between 1 to 10 years, and have worked in community clinics, schools, higher education, or private practice settings. An identified disability in this study was defined as the presence of physical, developmental, cognitive, and sensorial conditions that significantly impacted daily functioning (occupational, educational, relational), that were aware to the client, and that might have granted them access to government assistance in the form of Supplemental Security Income (SSI) or to an Individualized Education Program (IEP).

For the purpose of this study, disability was defined as physical, developmental, cognitive, and sensorial conditions. However, disability as a construct is artificial and complex. Participants might have clients who use a wheelchair. However, the experience of using a wheelchair will be unique based on the client's history. For instance, the experiences of people who are born with physical disabilities that require the use of a wheelchair and people injured in combat can be vastly different.

The recruitment of participants initially focused on the North Atlantic region of the Association for Counselor Education and Supervision (ACES) and extended to other ACES regions (Southern, North Central, West, and Rocky Mountains) to meet the recruitment needs. Participants were selected through purposeful snowball sampling (Hays & Singh, 2012). Upon IRB approval, I used two strategies to recruit participants. First, I used public repository of licensed professional counselors' information available in the websites of the Departments of Licensing and Labor of the states initially considered. Second, I accessed alumni listservs from different NARACES' CACREP accredited programs by contacting department Chairs in the Fall

2016 and requesting them to forward my research invitation to alumni who might be practicing as licensed professional counselors within the region.

Once these participants agreed to participate, they signed the informed consent forms. As I engaged in the relationship-building process, I asked if potential participants knew and could refer other licensed professional counselors who met the criteria for the study. The data were collected in two rounds of interviews. Each round included one semi-structured interview and one member check-in in the form of an interpretive dialogue interview. All semi-structured interviews and interpretive dialogue interviews were conducted in English, in person or through video-based communication (Skype or Facetime). Interviews were audio recorded and transcribed. Given the aforementioned appropriateness of qualitative inquiry and grounded theory tradition to describe the underlying process within a certain phenomenon, this study used grounded theory as it offered the most appropriate approach to answer the research questions in this study. See Chapter III for an expanded rationale for the use of grounded theory as well as for further details about participants, procedure, and analysis.

Conclusion

This qualitative inquiry aimed to examine the processes and dimensions that underlie the development of disability competence in licensed professional counselors. Twenty licensed professional counselors who were currently working with clients with disabilities were interviewed in multiple rounds to guarantee the accuracy and richness of their descriptions. By having multiple rounds of interviews I collaborated with my participants in expanding and deepening their initial descriptions. Grounded theory was chosen as the qualitative methodological tradition because it offered the most appropriate approach to answer the research questions in this study.

Additionally, this study sought to honor the qualitative and feminist values of embracing diversity and integrating personal descriptions of lived experiences by providing a forum for licensed professional counselors to describe their development of disability competence. By amplifying these counselors' perspectives, the findings of this study can contribute to enhancing the quality of disability training in counselor education programs. Findings also have the potential to complement the current trends on multicultural education for counselors with implications emerging directly from the clinical experiences of professional counselors.

In Chapter II, I present a substantiation of the counseling literature related to multiculturalism within professional counseling and counselor education. I also unpack the cultural identity of disability as a dimension of multicultural competence within counseling. Moreover, I identify linkages between these arguments and the professional practice of licensed professional counselors, and highlight the need to examine their process of development of disability competence through some years of clinical practice. Chapter II describes in more detail the conceptual aspects of this study.

Chapter II: Conceptual Framework

Introduction

According to the US Census Bureau, individuals with disabilities are considered the largest minority group in the US, which represents approximately 18.7 percent of the overall population as of 2010 (Brault, 2012). Of the total U.S. adult disabled population in 2010, approximately 35 percent experienced mental health difficulties in combination with other physical and communication disabilities that significantly impacted their daily functioning (Brault, 2012). As with any other minority group status, disability does not occur in isolation from other cultural identities. Drum et al. (2011) described disability as a minority identity that, like other minoritized identities, intersects with all other privileged and marginalized identities, adding complexity to the social realities and wellness possibilities of clients with disabilities. As a group, however, people with disabilities experience higher rates of unemployment, poverty, etc.

The US Department of Health and Human Services (USDHHS, 2001) asserted that the mental health system is not efficiently equipped to attend to the needs of marginalized communities. For instance, approximately 20 percent of the 43.8 million non-institutionalized adults with mental health symptoms in 2013 did not receive any form of counseling service (US Substance Abuse and Mental Health Services Administration, SAMHSA, 2014). Even though the overall health of people with disabilities has been considered an important aspect of psychological wellbeing, community integration, and human dignity (USDHHS, 2005), disability is excluded as a dimension of identity when examining the descriptions of marginalized communities' utilization of mental health services.

The USDHHS (2001) identified counselor bias in clinical practice, research, and pedagogy, as a factor that plays into the difficulties in engagement of and service to marginalized communities in the mental health system (Smith et al., 2008). Just as many white counselors lack multicultural competence (Vinson & Neimyer, 2000), many able-bodied counselors lack disability competence that would foster the understanding of the psychosocial realities and needs of disabled clients (Reeve, 2000, 2006). Ableism can contribute to counselors discounting or overemphasizing particular aspects of disability in the counseling relationship. The bias can also influence a lack of awareness of the social and political dimensions of disability or its intersection with other identities (Reeve, 2000, 2006; Smart & Smart, 2006). Moreover, blaming minority individuals for their social struggles and counseling needs is another manifestation of counselor bias (Eriksen & Kress, 2008; Smart & Smart, 2006), which in combination with lack of competence in disability issues can significantly jeopardize the counseling relationship in counselors' work with clients with disabilities.

Given the complexity of variables that inform counseling service utilization by clients from minoritized groups, the competence to understand and engage multicultural communities becomes essential for professional counselors (Chang et al., 2009; Lewis, Bethea, & Hurley; 2009; Sue, Arredondo, & McDavis, 1992). The counseling profession has made important advancements in multiculturalism and social justice in research, training, and practice (Ratts & Pedersen, 2014). Professional counselors who are equipped with multicultural competencies could be prepared to address the mental health issues that impact minoritized groups. However, multicultural competencies might still be insufficient to fully equip counselors with specific disability competencies to adequately address disability-related issues. Moreover, given that these mental health issues create interpersonal, occupational, and financial consequences that

further marginalize people with disabilities, professional counselors' use of disability-related skills need to become a standard of professional practice (Chang et al., 2009; Lewis et al., 2009; Sue et al., 1992). In the following section, I provide a description of multiculturalism in counseling, multicultural training of counselors, institutional initiatives that influence multicultural preparation, disability competence in counselor education programs, and disability competence enacted in multicultural professional practice. This chapter ends with the description of my rationale for using qualitative methodology for this study.

Multiculturalism in Counseling

The counseling profession has sought to address the counseling needs of marginalized communities by integrating the principles of multiculturalism and the affirmation of diversity in training programs (Arredondo & Toporek, 2004). The common rationale for the integration of multiculturalism in counseling is the responsibility of the profession to respond to changes in the representation of identities in society. For instance, ethnic marginalized communities are increasing in number, and they are expected to represent 50 percent of the U.S. population by 2050 (Hays, 2008; Ratts & Pedersen, 2014). Given that approximately 18.7 percent of the overall population had a disability in 2010 (Brault, 2012), the increased recognition and inclusion of disabled individuals in counseling services (Smart & Smart, 2006) creates opportunities for counselors to be multiculturally responsive to disability-specific needs.

Because licensed professional counselors are an important part of the mental health workforce in the service of marginalized communities, there is a strong impulse to integrate multiculturalism and promote the development of multicultural competencies within the counseling profession. Hill (2003) situated the development of multicultural competencies as an imperative for counselor training programs, in order to respond to client needs, professional

standards, ethical responsibilities, and student development. In response to the documented counseling needs of marginalized communities (Chang et al., 2009; USDHHS, 2001), the promotion of culturally responsive behaviors by professional counselors becomes a priority for the overall field (Arredondo & Toporek, 2004, Hill, 2003).

The increased sense of social responsibility and multiculturalism within the counseling profession has manifested in multiple ways. First, the Association for Multicultural Counseling and Development (AMCD) was established in 1972 and was aimed at the inclusion of marginalized identities in the counseling practice and discourse (Arredondo & Toporek, 2004; Ratts & Pedersen, 2014). From its foundation, AMCD assumed leadership "to assist the mental health professions in recognizing the assets of culture, ethnicity, race, and other social identities as indelible dimensions of every human being" (Arredondo & Toporek, 2004, p. 45) given the antecedents of scientific racism within counseling (Ratts & Pedersen, 2014). Examples of scientific racism within counseling are the historical misrepresentation of minority identities in counseling research, counseling and therapy texts, clinical training, and leadership positions (Arredondo & Toporek, 2004; Ratts & Pedersen, 2014).

Second, throughout the last 30 years, multiculturalism has been positioned by scholars and leaders as a driving and philosophical force within the counseling profession (Pedersen, 1991; Pieterse et al., 2009). This change in the language and general discourse of the profession legitimized the need for social responsibility and appreciation of diversity within professional counseling practice, pedagogy, and research (Pieterse et al., 2009). For Pedersen (1991), multiculturalism referred to "a wide range of multiple groups without ranging, comparing, or ranking them as better or worse than one another and without denying the very distinct, complementary, or even contradictory perspectives that each group brings with it" (p. 4).

Moreover, the counseling profession situated multiculturalism as a force at the core of counselor professional identity to respond to the historical marginalization of individuals based on their ethnic, racial, cultural, and socioeconomic differences (Arredondo & Toporek, 2004).

Third, following the creation of AMCD, Sue et al. (1992) defined a set of multicultural competencies, which were operationalized by 1996 (Arredondo et al., 1996; Arredondo & Toporek, 2004). With this set of professional standards, multiple identities, subcultures, and other factors of multiculturalism were provided as a reference to understand and embrace individual complexity within the counseling discourse (Arredondo et al., 1996). Since then, knowledge, awareness, and skills have been considered the preliminary multicultural trifecta to ground discussions of multiculturalism in the counseling profession (Pieterse et al., 2009) and to guide professional standards of practice and training. Additionally, the dynamism of multicultural development within the profession has served as a catalyst for the recent update of the 2015 Multicultural and Social Justice Counseling Competencies (Ratts et al., 2016).

Institutional Initiatives that Influence Multicultural Preparation

Along with the demographic changes and the increased recognition of multiculturalism in the US, the counseling profession has grown in its response to the related needs of privileged and vulnerable populations engaged in mental health services (Leong, 2008). Initiatives at the level of professional associations reify professional commitments to the wellbeing of minority communities as well as the expectation for licensed counselors to be multiculturally skilled and competent in their work with marginalized communities, including clients with disabilities.

American Counseling Association (ACA)

The establishment of the counseling profession in America has been facilitated by the creation of professional organizations. Formerly known as the American Personnel and Guidance

Association, the American Counseling Association's (ACA) main goal is the development and enhancement of the counseling profession through the establishment of ethical standards, as well as the promotion of accreditation, state licensure, and certification at the national level (Foster, 2012). Moreover, with the endorsement of ACA, the counseling profession has been a pioneer in developing a philosophical grounding and professional identity that strays from medicalized views of mental health towards a holistic approach informed by wellness and an emphasis in education, prevention, development, and social justice (Chang et al., 2010). ACA houses a variety of divisions intended to focus on specific areas of the counseling profession. In terms of disability, the American Rehabilitation Counseling Association (ARCA) focuses on rehabilitation issues for personal, career, and independent living goals through the counseling process (ARCA, n.d.).

Moreover, ACA's leadership within the profession has facilitated the emergence and legitimization of the multicultural discourse in different ways. As previously explained, ACA supported and endorsed the creation of AMCD as a division focused on addressing racial issues in counseling (Arredondo & Toporek, 2004). Since then, ACA has consistently emphasized and advocated for the appreciation and affirmation of diversity within the ethical code of the profession (Arredondo & Toporek, 2004; Pieterse et al., 2009).

For instance, ACA's 20/20 initiative has delineated strategic areas for the advancement of the counseling profession in the US by 2020 (Kaplan & Gladding, 2010). By coordinating and ensuring the participation of the majority of organizations within counseling, ACA defined a long-term plan for the development of the profession that entailed efforts towards achieving an unified professional identity, license portability, and client welfare. The promotion of client welfare and advocacy for the populations served are positioned as the primary focus of the

counseling profession, and reiterate the multicultural commitment for inclusion and social justice (Kaplan & Gladding, 2011).

Additionally, ACA has established and promoted the code of ethics to guide the counseling practice, pedagogy, and research in the US (ACA, 2014). The ACA's *Code of Ethics* (2014) stresses the importance for counselors to maintain awareness and sensitivity regarding cultural meanings of confidentiality (B.1.a), diversity issues in diagnosis (E.5.b) and assessment (E.8), and the impact of multiculturalism and diversity in the supervision relationship (F.2.b). As a fundamental grounding of professional standards for training and practice, the ACA's *Code of Ethics* (2014) defines multicultural counseling as a professional practice "that recognizes diversity and embraces approaches that support the worth, dignity, potential, and uniqueness of individuals within their historical, cultural, economic, political, and psychosocial contexts" (p. 20).

Furthermore, in this ethical code, multicultural competence is defined as "counselors' cultural and diversity awareness and knowledge about self and others, and how this awareness and knowledge are applied effectively in practice with clients and client groups" (ACA, 2014, p. 20). This ethical code represents the profession's institutional deep commitment to multiculturalism and the honoring of values of equity and human dignity. Throughout the ACA's *Code of Ethics* (2014), disability is integrated as an identity within multiculturalism that requires counselors' competence. For instance, in the ACA's *Code of Ethics* (2014) document, disability is mentioned when highlighting counselors' professional responsibility for non-discrimination (C.5), for diversity awareness in assessment (E.8), and for multicultural accommodations (H.5.d). The ACA's *Code of Ethics* (2014) stipulates concrete areas of diversity consciousness that inform the training of counselors as well as all other areas of the counseling profession.

Council for Accreditation of Counseling and Related Educational Programs

ACA's ethical principles of professional excellence also inform the standards for the accreditation of specialized counseling training (Foster, 2012; Leong, 2008). Training programs that are accredited by CACREP follow intentional professional objectives and meet detailed requirements to guarantee the development of multicultural competencies in counselor preparation (Dodson, 2013). CACREP standards are periodically revised, with the last revision being enacted in 2016. These revisions help counselor education programs to stay current with the societal demands and contextualized social dynamics that impact practitioners as well as counselor educators (Foster, 2012). In the 2016 CACREP standards, multiculturalism is positioned as the professional core disposition of social and cultural diversity within the curriculum. One of eight curricular core areas, this core area stresses the importance of learning objectives related to pluralistic characteristics within and among diverse groups, theories of identity development and social justice advocacy, the effect of power and privilege, the impact of counselor's views, strategies for addressing barriers and oppression, as well as the multicultural competencies (Standard 2.F.2).

Counseling standards situate multiculturalism as a foundational aspect of counselor curriculum (Pieterse et al., 2009). Hence, programs applying for and requesting accreditation are explicitly required to provide evidence of learning objectives that emphasize the training in diversity, as well as the effects of social inequalities, oppression, and injustice, which lead to specific mental health outcomes for marginalized communities (Chang et al., 2009; Pieterse et al., 2009). Also, diversity and cultural aspects of professional practice are integrated as specific standards within the contextual dimensions of each of the entry-level specialty areas and doctoral standards.

For instance, in CACREP standards (2016), disability is framed as a cultural identity represented in the specific track of clinical rehabilitation counseling (5.D). In this specialty area, the emphasis is placed on the foundational aspects of rehabilitation counseling as well as the contextual dimensions of disability that define social, legislative and cultural factors of this identity. Counselor training programs adhering to CACREP standards (2016) can work towards the accreditation of this specialty area and reify multicultural commitments by pursuing learning objectives related to disability through this track.

Additionally, along with Sue et al.'s (1992) emphasis on counselors' awareness of multicultural issues, biases, prejudices, and assumptions, CACREP standards compel counselor preparation programs to emphasize students' self-exploration and awareness building about potential personal values and perspectives that impact the counseling relationship (Wilkinson, 2011; CACREP, 2016). For instance, Watt et al. (2009) found paternalistic and ableist reactions in counselors journaling about disability content presented in class. These authors further asserted that self-exploration could be fostered in students by encouraging them to establish meaningful conversations with peers and faculty about diversity issues, which address students' internalized ableism, and their reactions to privilege and other cultural artifacts that perpetuate oppression (Watt et al., 2009). Hence, CACREP requirements for multicultural competence in professional standards of practice and research align with the counseling professions' fundamental commitments for multiculturalism and diversity, which are enacted by the counselor preparation community, students, faculty and stakeholders (Wilkinson, 2011).

National Board of Certified Counselors (NBCC)

Counselor certification entails the verification of "rigorous standards for training, specialized knowledge, and supervised experience" (Foster, 2012, p. 45) that seeks to bring

nationwide uniformity to the profession (Foster, 2012). The most relevant counseling credential in the US is the National Certified Counselor (NCC), which is administered by NBCC through the standardized National Counselor Examination (NCE). The NCE also functions as the licensure exam for some states across the country.

Another test administered by NBCC is the Counselor Preparation Comprehensive Examination (CPCE). This test is a comprehensive exam that offers an objective view of the students' knowledge in various curricular areas, and is taken by students at the end of their course of study. CACREP ensures that counselor training nationwide responds to a core set of dispositions that prepare students to successfully pass the NCE and CPCE examinations and further their professional identity as nationally certified counselors (Leong, 2008). Thus, "accreditation and certification work together to uphold the specific body of knowledge for the counseling profession" (Foster, 2012, p. 46).

The NCE and CPCE assess specific content areas related to social and cultural diversity. These tests evaluate student's knowledge in multiple core areas, one of them being the multicultural intricacies of professional counseling. Disability as an aspect of cultural diversity is reflected in the assessment of multicultural knowledge in these tests.

Commission on Rehabilitation Counselor Certification (CRCC)

Another widely recognized counseling national certification is the Certified Rehabilitation Counselor (CRC) credential offered by the CRCC. The CRC is the main certification related to disability assessment, policy, occupational aspects, as well as grounding counseling principles of professional practice (Foster, 2012). This certification requires multicultural knowledge in social and cultural issues related to disability identity. Counseling training programs accredited by the Council of Rehabilitation Education (CORE) concentrate in

education and experience in rehabilitation counseling and disability issues. CORE accredited training programs prepare students to achieve the CRC credential (Foster, 2012).

Thus, the main counselor certifying bodies in the US are NBCC and CRCC through their accrediting training councils CACREP and CORE (Foster, 2012). These organizations have sustained productive conversations for their merging or unification (Leong, 2008). By the time of this proposal, CACREP has officially defined CORE as its affiliate and has announced the plans to complete a final round of conversion application of the programs seeking to grant dually accredited status as both Clinical Rehabilitation Counseling and Clinical Mental Health Counseling programs (CACREP, 2016). The merging of both accrediting organizations is expected to occur in July 1, 2017, and represents important opportunities for the enhancement of the multicultural discourse by intentionally integrating disability in standards of excellence in counseling pedagogy, research, and professional practice.

American Association of State Counseling Boards (AASCB)

Counseling state licensure is regulated by the AASCB and usually requires holding a master's degree, the accrual of supervised hours, and a passing score in a performance examination (Foster, 2012; Leong, 2008). Licensure represents the most comprehensive step in the professionalization of counselors in the US (Foster, 2012), which guarantees the accrual of supervised practice and a robust knowledge base in preparation to serve the complex needs of privileged and minority clients. The counseling licensure examination also requires the enactment and application of multicultural competences. Furthermore, in order to maintain state licensure, professional counselors are required to engage in demonstrated professional development and ethical practice, which entail the continual enactment of multicultural competence.

In summary, the most recognized institutional bodies in the counseling profession work in alignment with fundamental commitments of specialized counseling knowledge and multicultural competence and sensitivity. These institutional initiatives create professional synergies that inform the multicultural preparation of counselors as well as the expectation for multicultural practice of licensed professional counselors. Moreover, given the professional expectations of multicultural competence that are reified by these institutional initiatives, counselor education programs have the responsibility to infuse issues of multiculturalism throughout the counselor curriculum.

Multicultural Training of Counselors

As stated before, the last three decades have proven the profession's commitment for the appreciation of diversity as an essential consideration in pedagogy, professional practice, and scholarship (Pieterse et al., 2009). Counseling multicultural practice has therefore evolved in congruence with institutional initiatives to launch and foster multicultural competencies in the training of counselors as well as in their licensed professional practice. In 1992, Sue et al. defined a distinct set of knowledge, behaviors, and skills in the domains of counselor awareness, understanding of client's worldview, and cultural intervention strategies (Arredondo & Toporek, 2004; Pieterse et al., 2009). With this, multiple identities and factors of multiculturalism were provided as a reference to understand and embrace individual complexity within the counseling discourse (Arredondo et al., 1996). Since then, the dimensions of knowledge, awareness, and skills have served as a framework to ground discussions of multiculturalism in the counseling profession (Pieterse et al., 2009) and to inform counseling practice and training. In this section, I juxtapose these three components of multicultural training and disability and further describe the

contemporary shifts in the multicultural discourse towards enhanced conceptualizations of identity.

Knowledge, Awareness, and Skills

Multicultural knowledge relates to "the facts and information about cultures [that] are available in the people, the literature, and the products of each culture at the local, national, and regional levels" (Ratts & Pedersen, 2014, p. 91). This set of cultural information is thought to be an important aspect that assists counselors in the understanding of unfamiliar cultures and to facilitate the gaining of multicultural awareness and the development of multicultural skills (Sue et al., 1992). The multicultural knowledge related to disability competence is mainly delegated to specific lectures within multicultural courses (Pieterse et al., 2009) and elective (rather than required) classes in counselor training programs. Moreover, disability knowledge even when included is usually situated in traditional rehabilitation discourses and medicalized models of disability (Reeve, 2000; Smart & Smart, 2006)

Multicultural awareness is an essential step in the process of becoming multiculturally competent. It is the basis for counselors to accurately compare and contrast "alternative viewpoints, relate or translate priorities in a variety of cultural settings, identify constraints and opportunities in each cultural context, and have a clear understanding on one's own limitations" (Ratts & Pedersen, 2014, p. 91). Multicultural awareness also works in a reciprocal relation to knowledge and skills by providing an individual basis for accurate attitudes and beliefs about the social world. In terms of disability awareness, studies have demonstrated the limited emphasis on counselors' examination of able-bodied privilege and its potential impact on the counseling relationship (Reeve, 2000; Watt et al., 2009). The documented counselors' able-centrism

reiterates the importance of addressing knowledge and attitudes towards disability in counselor training and professional practice.

Multicultural skills relate to the sensitive planning, conducting, and evaluating of the multicultural context by interacting, counseling, interviewing, advising, and managing multicultural tasks effectively (Ratts & Pedersen, 2014). Moreover, multicultural competencies play an important role in how the counselors connect with the clients they serve (Dodson, 2013; Ratts & Pedersen, 2014). In terms of disability, counselors' multicultural skills are evidenced by enhanced engagement skills, non-judgmental approach, holism, active listening, and empowerment of clients with disabilities (Swain et al., 2006). Further, Reeve (2000) stressed the need for counselors to develop the necessary skills to recognize and address the sociopolitical complexities of disability in the counseling relationship (Reeve, 2000, 2006).

The USDHHS report (2001) and Matthews-Juarez and Juarez (2011) have situated increased responsibility on counselors for developing a culturally competent and sensitive mental health system through their continual self-examination aimed to develop awareness of their own biases and stereotypes. They also state the importance for counselors to understand the history and general knowledge about the current dynamics pertaining to privileged legacies in the mental health system, and gain multicultural skills to engage individuals and families based on their specific contextual background (Matthews-Juarez & Juarez, 2011). In other words, the development of multicultural competencies has been framed as a necessity for counselors, who are not considered effective if not equally versed in all areas of multiculturalism (Arredondo & Toporek, 2004; Ratts & Pedersen, 2014). Additionally, specific multicultural competences related to disability have been postulated as an urgent need in the training and practice of

counselors (Smart & Smart, 2006; Smith et al., 2008). These assertions align with the profession's commitments for equity, inclusion, and multicultural sensitivity.

The initial writing and subsequent revisions of the competencies have made it a living document that has engaged professional counselors and leaders in clarification, substantiation, and robust dialogue about multiculturalism in the profession (Arredondo & Toporek, 2004). The infusion of multicultural competencies in counselor curriculum, supervision, and research has been highlighted as a priority (Hays, 2008; Hill, 2003; Holcomb-McCoy, 2005; Lewis et al., 2009; Pieterse et al., 2009). Further, the operationalization of multicultural competencies has facilitated scale development and measurement of multicultural dispositions in counseling training and professional practice (Arredondo & Toporek, 2004). According to Hays (2008), the "assessment of [multicultural] competencies is necessary to ensure culturally appropriate counseling services to an increasingly diverse clientele" (p. 95). In short, the multicultural emphasis and commitment within the counseling profession have situated these competencies in the foreground for the optimal and sensitive services offered to marginalized communities and have also furthered the discourse in training and practice of counselors.

Multiculturalism in counseling has increasingly required the integration of multidimensional conceptualizations of identity that facilitate the recognition of oppression awareness and social justice within professional standards of teaching and practice (Hays, 2008; Vera & Speight, 2003). Grounding multiculturalism at the core of professional identity has set a precedent in the profession by emphasizing the importance of embracing diversity and integrating all groups in society, social justice emphasizes on the importance of addressing oppressive and marginalizing realities that these communities face (Ratts & Pedersen, 2014; Vera & Speight, 2003).

A Shift Towards Social Justice Advocacy

Social justice advocacy is a growing presence in the multicultural literature and training of counselors (Pieterse et al., 2009). According to Chang et al. (2009), the increased awareness about the social realities of marginalized communities has led to the shift towards social advocacy as an important part of counselors' training and responsibilities. This has been evidenced in the integration of social justice advocacy in the latest version of the multicultural competencies for counselors (Ratts et al., 2016). The current version of the multicultural competencies in counseling was again endorsed by AMCD in 2015 and has expanded its scope to include social justice as a domain of multicultural competence. This document offers a framework to enhance counseling theory, practice, and research, while seeking to highlight the intersecting aspects of cultural identity, as well as the dynamic forces related to power, privilege, and oppression that impact the counseling relationship. This version of the competencies provides conceptualizations in advocacy interventions aimed to foster social change (Ratts et al., 2016) that can be applied to the work with marginalized individuals, including clients with disabilities.

Social justice in counseling has been considered both a goal and a process, and advocacy has been considered the vehicle for the enactment of values of justice and human dignity (Chang et al., 2010). Social justice advocacy is then positioned as an aptitude to be developed along other multicultural competencies in counselor preparation. Social justice advocacy is a furtherance of the initial Advocacy Competencies developed by Lewis, Arnold, House, and Toporek (2003). The Advocacy Competencies (Lewis et al., 2003) offer specific strategies for counselors to enact the evolving values of the profession to meet the needs of the diverse

populations served while also addressing the impact of systemic oppression, privilege, and discrimination on the mental health of these clients (Chang et al., 2009).

The integration of social justice and advocacy dimensions to the development of multicultural professional identity enhances the counseling approach to include socio-political aspects of minority clients' lives (Ratts et al., 2016). This advancement in the multicultural discourse represents meaningful potentialities for professional counselors to do what Reeve (2000), Smart and Smart (2006), and Swain et al. (2006) suggested as the need to incorporate psycho-emotional and political aspects of navigating a disabling society within counseling work. Thus, the counseling profession is growing in ways to respond to social responsibilities related to the lives of minority clients (Ratts & Pedersen, 2014).

In summary, the multicultural discourse in professional counseling has evolved to embrace action-oriented competencies aimed to create social change, which have been powered through synergistic conceptualizations of identity (Ratts et al., 2016). These conceptualizations have emphasized the critical examination of identities' interplay and transactions of power in the counseling relationship (Ratts & Pedersen, 2014). Also, the shift towards intersectional conceptualizations of marginalized identities in counseling has led to the emergence of models aimed to help counselors operate according to clients' qualitative experiences defined by their intersecting identities (i.e., Sim Chun & Singh, 2010; Singh & Sim Chun, 2010). In the following section, I deepen the descriptions of disability competence in counselor education programs by highlighting its silencing and training paucities in counselor preparation.

Disability in Counselor Education Programs

Within the multicultural discourse in counseling, the definitions and the general understanding of disability have been traditionally situated in the biomedical model, which

highlights an emphasis on pathology and deficit (Pledger, 2003; Reeve, 2006). These traditional conceptualizations have fostered the reduction of people's experiences to a binary of able-bodied or disabled bodies (Olkin & Pledger, 2003; Linton, 1998). Even though these conceptualizations have significantly influenced professional standards of counselor preparation, research, and professional practice (Reeve, 2000), more contemporary approaches to social issues in the counseling profession have fostered shifting views related to the rehabilitation of clients with disabilities. The next section describes the nature of disability training in the preparation of counselors, as well as the emerging conceptualizations of disability in the multicultural discourse.

Disability Training in Counselor Education Programs

Traditionally, mental health professionals have received limited training in issues related to disability and rehabilitation (Pledger, 2003). In instances where rehabilitation issues have been addressed within counselor preparation, clients' lives have been examined from a deficit-oriented lens (Goodley & Lawthom, 2006; McCarthy, 2003; Olkin & Pledger, 2003). Moreover, despite the counseling profession's endeavors for the enhancement of the multiculturalism in training and practice, disability's psychological and socio-political aspects have been rarely addressed in the counseling discourse (Olkin & Pledger, 2003; Swain et al., 2006).

Silencing of disability in counselor training. In general, disability remains largely silenced in the training of counselors and marginalized in the multicultural discourse (Olkin & Pledger, 2003; Reeve, 2000; Smart & Smart, 2006; Smith et al., 2008). Some authors have identified reasons for this absence. First, disability has been traditionally understood as the result of biological difference that results in clients with "exceptional" needs (Olkin & Pledger, 2003, p. 297). When clients with disabilities experience a variety of social, financial, and legal

implications, these are seen as inevitable aspects of disablement. Furthermore, "because disability status has been viewed as a defect rather than a dimension of difference, disability has not been widely recognized as a multicultural concern by the general public nor by counselor educators and practitioners" (Smith et al., 2008, p. 86). The absence of disability as a multicultural concern within counseling and psychology is in reciprocal relation to the silencing of disability in counselor curriculum, recruitment, retention, and research (Olkin & Pledger, 2003). Olkin and Pledger (2003) highlighted the need to include personal accounts of lived experience from people with disabilities when theorizing and producing scholarly knowledge about them. The lack of representation of disabled communities (as subjects of study and researchers) in the production of knowledge has been considered counterproductive, further marginalizing, and overtly oppressive (Charlton, 1998). Thus, the silencing of disability in the training of counselors is incongruent with anti-oppression scholarship that highlights the importance of inclusion of disabled people's accounts in the making of everyday life (Charlton, 1998).

Second, given the diversification of counseling specialties in the U.S., disability components have been mainly associated with rehabilitation counseling (Smart & Smart, 2006), resulting in decreased opportunities for disability representation in the training of counselors of other specialties (Smith et al., 2008). Disability has been traditionally considered a concern of rehabilitation counselors who assist people in the adjustment, restoration, and re-integration of people with disabilities to their existing environments (Pledger, 2003; Smart & Smart, 2006). However, Smith et al. (2008) asserted the increasing need for disability-related counselor competence that moves beyond the realm of rehabilitation notions of different abilities and extends to the work related to support families and parents of people with disabilities, school

counseling, career decisions and employment counseling, mental health counseling, and self-advocacy to be used in the navigation of a disabling society.

Olkin (1999) and Olkin and Pledger (2003) further asserted that disability, as a cultural identity, is largely absent in the mainstream curriculum of psychology and counseling training, as well as research and scholarship. Specifically in the preparation of counselors, clinical courses can be the first opportunity for students to provide services to persons with disabilities, and therefore, confront their perceived competence in working with these clients (Pledger, 2003). Particularly in CACREP accredited programs, disability is integrated in curriculum as an aspect of multiculturalism rather than a separate clinical disposition. Many authors have documented the indifference to disability as an identity within the multicultural discourse and professional standards of teaching and practice (Reeve, 2000; Smart & Smart, 2006; Smith et al., 2008).

For instance, in the most recent accreditation standards for counseling programs (CACREP, 2016), disability is underrepresented across the document. CACREP standards (2016) entail eight core areas of counselor training: professional counseling orientation and ethical practice, social and cultural diversity, human growth and development, career development, counseling and helping relationships, group counseling and group work, assessment and testing, and research and program evaluation. When disability is examined across the standards document, disability is defined as "different physical, emotional, and mental abilities" in the glossary (CACREP, 2016, p. 42). Thus, disability is defined as pertaining to the individual and not to the environmental structures. Even though disability is embedded in multicultural descriptions of counselor preparation and assumed to be present throughout the counselor education curriculum, the enunciation and representation of disability in CACREP standards (2016) is not explicit as an aspect of multiculturalism.

Furthermore, disability as a cultural minority can be reinscribed within the social and cultural diversity core disposition, grounding disability content within counselor training and multicultural competence. Specifically, this core disposition refers to the preparation of counselors to respond to the counseling needs of multicultural groups by integrating multicultural competencies in work with them. Counseling training standards (CACREP, 2016) also seek to address attitudes, beliefs, and individual views of cultural differences, while acknowledging and embracing the dimensions of power and privilege in the work with minority clients.

As an additional enactment of the profession's multicultural commitments, CACREP training standards (2016) require counselors to develop social justice advocacy competencies to ground the counseling work in real possibilities for social change in minority communities. Lastly, students need to demonstrate learning outcomes related to the elimination of barriers, prejudices, and processes of intentional and unintentional discrimination against minority and historically oppressed groups. From this point of view, training core dispositions related to social and cultural dimensions could afford a venue for the development of disability competence in counselor training, however, disability competence is not yet directly or explicitly mandated in counselor curriculum.

Disability in the multicultural counseling course. The didactic enactment of the social and cultural diversity CACREP core disposition is usually situated in a discrete multicultural training class. Thus, "the single-course approach is still the tool most frequently used for multicultural training" (Pieterse et al., 2009, p. 97) for counselors of all specialties (Lewis et al., 2009). In the multicultural course, disability content is generally reflected as part of the curricular design in the form of a population-specific lecture and in isolation from other identities

(Lewis et al., 2009; Pieterse et al., 2009). Thus, the integration of disability content in the multicultural class represents different challenges and opportunities.

In a content analysis of 54 multicultural and diversity-related course syllabi from counseling and counseling psychology programs accredited by CACREP and the American Psychological Association (APA), Pieterse et al. (2009) identified several themes that account for the representation of some minority identities as well as issues in the curricular enactment of the profession's multicultural commitments of social justice advocacy. In this study, Pieterse et al. aimed to create a data-driven analysis of multicultural competence and social justice training by conducting an online search of counseling programs, identifying multicultural program instructors, and requesting their most recent class syllabus. With a response rate of 37 percent, the authors received multicultural syllabi from masters (n=25, 46%) and doctoral (n=29, 52%) programs from all regions of the country. Approximately half of the study's sample accounted for programs located in the South and was mainly from CACREP-accredited counseling programs.

Pieterse et al. (2009) identified course content and counted their frequencies in the sample of syllabi examined. Examples of course content identified by the authors included: multicultural concepts, racial identity, racial/ethnic groups, racism, counseling interventions, social justice, forms of oppression, and specific populations, among others. This finding is congruent with the "population-specific" (Pieterse et al., 2009, p. 107) approach used in the multicultural education of counselors, and represents opportunities for the underscoring the examination of specific historical factors, values, and cultural components that inform disability identity. However, as reflected in the syllabi content review, the coverage of varied identities and

their contextual variables is enacted in an inconsistent manner in the multicultural education of counselors (Pieterse et al., 2009).

For instance, within the category of special populations, "disabled" (Pieterse et al., 2009, p. 103) was identified in 12 syllabi as a particular population of study, which represented 29 percent of the documents reviewed. In other words, disability is documented in syllabi as a learning objective only once out of three times. Moreover, ableism as a type of discrimination that perpetuates oppression and marginalization of differently-abled clients was documented in only four syllabi, or 7 percent of the syllabi reviewed (Pieterse et al., 2009). Thus, even though the limitations of Pieterse et al.'s (2009) study refer to the partiality of what is documented in the syllabi compared to the richness of potential discussions emerging in the multicultural class, there is a significant underrepresentation of disability-related content documented in the syllabi reviewed and decreased opportunities for disability competence development in counselor multicultural training. Detailing disability content in syllabi in one way to ensure the systematic coverage of such material across the course.

Cultural competence has also been examined in the multicultural curriculum of rehabilitation education programs. Lewis et al. (2009) stressed the need to offer more direction for rehabilitation educators on how to integrate cultural competency throughout the program of study and how to not restrict it to the required course in multicultural counseling. In the literature review conducted by Lewis et al. (2009), the authors emphasized the need to move from a model that fosters single lectures for each identity to an infusion approach that waves multicultural content throughout the rehabilitation counseling curriculum, accreditation standards, professional practice, and research. The infusion approach supported by different authors (i.e., Hays, 2008; Lewis et al., 2009; Pieterse et al., 2009) could exponentially create more opportunities for

counteracting the documented silence of disability content. Lastly, this approach could foster enhanced multicultural competence by integrating disability content into other core areas of counselor training such as professional counseling orientation and ethical practice, counseling and helping relationships, and assessment and testing (Lewis et al., 2009).

Manifestations of the lack of disability competence. Counselors' lack of preparation in disability competence can result in a continuum of responses ranging from overly focusing on to ignoring the disability in their clinical work (Olkin & Pledger, 2003; Parkinson, 2006). Also, this lack of preparation could jeopardize the counseling relationship if counselors are oblivious to their own negative reactions to disability (Reeve, 2000, 2006; Sheaffer et al., 2008; Watt et al., 2009), or focus exclusively on loss and grief as intrinsic processes related to disability (Reeve, 2000). Thus, the lack of training can lead to further marginalization of disability if counselors do not understand disability as simply another dimension of diversity (Pledger, 2003).

Olkin and Pledger (2003) contributed a conceptual article that described how medicalized conceptualizations of disability in psychology and other mental health professions can impact the way clinicians engage clients with disabilities. Along with documenting the presence of deficit narratives of disability (Davis, 2013), these authors noted the absence of disability training and decreased self-examination of biases as the fundamental factors leading to lack of disability competence in students. Specifically, Olkin and Pledger (2003) explained the impact of clinician's narrow able-bodied perspectives on their ability to understand the clients' presenting needs and demonstrate cultural competence to appropriately serve them. Moreover, different authors have also documented how a lack of awareness can impact the ability of clinicians to work with clients with disabilities (Reeve, 2000; Smart & Smart, 2006; Smith et al., 2008).

In a 3 year qualitative study that examined nine master's students' reaction to difficult dialogues in the classroom, Watt et al. (2009) analyzed student journal entries and reaction papers throughout a fifteen-week didactic course on multiculturalism in a US Midwestern university. From the total sample, five students were pursuing a master's degree in school counseling, two students were pursuing master's degrees in rehabilitation counseling, and other two in affairs counseling respectively. The sampling description of this study did not provide information about disability identity of the participants.

Using consensual qualitative research method, the authors identified eight typical students reactions to dialogues about cultural differences. These reactions included: denial, deflection, rationalization, benevolence, intellectualization, minimization, principium, and false envy. Students demonstrated reactions of false envy in order to "demonstrate affection for a person or a feature of a person rather than commenting on the complexity of the social and political context" (Watt et al., 2009, p. 49).

Even though any of these eight identified reactions can emerge in response to dialogues about disability in the classroom, Watt et al. (2009) documented disability as a cultural identity that typically triggers responses of false envy in counseling students. Specifically, Watt et al. (2009) emphasized the students' shared admiration for people with disabilities,

> 'God gives disabilities to people who could cope with them.' I think that this says a lot about people with disabilities. Every time I talk to someone with a disability I gain a much larger appreciation and more respect for them. I think what I am trying to say is that maybe sometimes I wish that I had a disability (p. 49).

According to Watt et al. (2009), false envy statements also account for admiration and inspirational attributions that are problematic and largely documented as potent biases impacting

the lives of people with disabilities (Linton, 1998; Reeve, 2000). These inspirational views of disability are problematic inasmuch as they perpetuate objectifying, reductionist, dehumanizing explanations of disabled experiences.

In this study, the students' written articulation of their reactions from class provides significant insight about their held beliefs that could potentially impact their work with clients. Finally, the authors emphasized the need for counselor education programs to prepare students to reflect on their different cultural identities and understand the impact of dominant cultural identities as well as how privilege and biases can influence the counseling work. The findings of this study indicate that counseling students hold problematic biases about people with disabilities.

The biases toward persons with disabilities have also been identified as leading to further marginalization of disabled clients. Sheaffer et al. (2008) conducted an exploratory study to examine the influence of students' socio-cognitive development on attitudes toward people with disabilities, as measured by preferred social distance. The authors surveyed 102 master's level students in health programs at a Southeastern university. The sample included students from different health-allied professions: rehabilitation counseling (19%), communication science disorders (31%), occupational therapy (16%), and physical therapy (34%). From the total sample, 11 percent of the participants identified as having a disability.

The quantitative data in this study was analyzed through multiple regression analysis and the findings indicated increased preferred social distance in inverse relationship to students' socio-cognitive development. In other words, even though the rehabilitation counseling students from this sample exhibited scores that suggested less need for social distance from people with disabilities, students at earlier stages of social and cognitive development manifested a

preference for higher social distance compared to those in more advanced stages of development (Sheaffer et al., 2008). Along with the ability for enhanced self-reflection in later stages of developmental maturity, Sheaffer et al. (2009) stressed the importance of providing opportunities for counselors to develop heightened empathy, openness to experience, and cognitive complexity in their work with clients with disabilities.

As a potential limitation to their study, Sheaffer et al. (2008) identified a reductionist categorization of students' social and cognitive development and the lack of acknowledgment of many other factors involved in student development. However, examining the maturational development of mainstream counseling students in the U.S. offers strong insight about the underlying processes that inform disability competence development throughout programs of study and during licensed professional practice. These authors further emphasized the need for educators to assist students in the transition to higher levels of socio-cognitive development, while infusing multicultural instruction aimed to enhance the competence to work with clients with disabilities.

Additionally, Reeve (2000) documented the potentially harmful consequences of "many counsellors who are unaware of their disablist attitudes which remain unrecognized and unchallenged" (p. 699). As a disabled counseling client herself, Reeve (2000) challenged biases commonly featured in the training and practice of professional counselors. First, Reeve (2000) questioned assumptions of psychological adjustment and loss that position disability as psychologically devastating experience or a personal tragedy, which can only be resolved by grieving. Second, Reeve (2000, 2006) opposed reductionist and medicalized narratives of disability and encouraged counselors and scholars to expand and diversify the conceptualizations of disability services to include the psychological effects of a disabling society on people's lives.

Third, Reeve (2000, 2006) highlighted the resulting distance in the counseling relationship that emerges from counselors' unexamined prejudices and assumptions about clients with disabilities.

Reeve (2000) further asserted that as long as these prejudices and assumptions are not addressed, professional counselors most likely play a part in the systemic oppression of disabled culture and strongly advocated for a training grounded in disability equity (Disability Equity Training, DET) as a way to enhance counselors' disability competence. Reeve (2000) stated, "unfortunately, my personal experience is that some counsellors believe that they already 'unconditionally accept all people' and therefore don't need DET" (p. 673). Reeve's (2000) statements further highlight the importance of understanding the processes that determine the development of disability competence in counselors' professional practice.

Finally, Parkinson (2006) conducted a qualitative investigation 25 counseling trainees' attitudes towards people with disabilities and through the introduction of DET in their training program. Parkinson (2006) identified strong synergy between four main themes that included: definitions and models of disability, disability awareness, interpersonal communication, and counseling relationship and confidentiality. In the study's findings, Parkinson (2006) asserted that half of the participants admitted to viewing people with disabilities as victims of their circumstances. Even though participants demonstrated enthusiasm for working towards the counseling relationship and collaborating with other professionals to reach the high standard of care for clients with disabilities, 75 percent of the participants formulated descriptions of disability in terms of loss (Parkinson, 2006). DET was positively evaluated by the participants as a venue for the development of competence around disability issues (Parkinson, 2006).

In short, the silencing or the misguided representation of disability in multicultural training courses has significant implications for the professional practice of counselors and other

mental health professionals (Olkin & Pledger, 2003; Parkinson, 2006; Reeve, 2000; Smart & Smart, 2006). Because of this, Smart and Smart (2006) have proposed that disability needs to be infused in multicultural commitments in a more visible way in counselor preparation, practice, and research. These changes not only could enhance the overall multicultural education of counselors, but they are also promising for counselors' development of disability competence.

Proposed curricular changes. Authors have proposed curricular and conceptual changes related to disability training for counselors and other mental health professionals (i.e., Olkin & Pledger, 2003; Pledger, 2003; Reeve, 2000, 2006; Shin et al., 2011; Smart & Smart, 2006). In a conceptual article, Pledger (2003) lays out the evolving dynamics in disability perspectives that increasingly stress the dynamic intersections of contextual factors that shape the disability experience. Pledger (2003) emphasizes the need to "add new voices to the discourse on disability and rehabilitation issues by broadening the discussion of disability an rehabilitation beyond those specialties traditionally viewed as having a chronic illness and disability focus" (p. 280). Pledger (2003) suggests the infusion of "theoretical foundations, historical perspectives, conceptual frameworks, terminology, and criteria for defining disability" (p. 279), which could facilitate a more contextualized understanding of disability, and increase disability competence in counselors and other mental health professionals.

Additionally, Reeve (2006) emphasized the need for counselors' disability training to include classes and lectures that cover the psycho-emotional dimensions of disability and the full impact of living in a disabling environment. Reeve (2006) asserted that psycho-emotional disablism results from society's unexamined biases and attitudes that lead people with disabilities to feel "regarded by others as someone to be feared and avoided" (p. 99). Thus, Reeve (2006) claimed that more importantly than focusing on individual aspects of disability, it

is imperative that training programs address the internalized negative values about people with disabilities that can heavily inform counselors' competence in working with this population.

Also, in a conceptual article, Smart and Smart (2006) suggested the curricular integration of additional models to conceptualize disability that detach from solely medicalized descriptions and incorporate social and political views of disability. Smart and Smart (2006) further suggested a list of implications for the counseling profession when training counselors to increase their disability competence. Specifically, Smart and Smart (2006) recommended training programs to foster counselors' awareness of own values and biases and the potential ways for these to be unintentionally imposed in clients with disabilities. Moreover, Smart and Smart (2006) called for counselors to critically examine their views of power in the counseling room, acknowledge the client's experiences of discrimination and prejudice, and embrace the complexities of disability as a minority group.

In another conceptual article, Smith et al. (2008) stressed the importance of students and educators' awareness of biases and assumptions related to disability. This is congruent with previous findings where Watt et al. (2009) underlined the importance of critical conversations to enhance awareness and sensitivity around minority identities. Smith et al., (2008) urged counselor educators to integrate curricular strategies aimed to "develop an awareness of how [disabilities] have an impact on clients' lives." (p. 305). These authors further asserted that this could be accomplished through intentional readings and conversations, as well as "intentionally including clients [or counselors] with disabilities in internship training" (p. 306).

Lastly, Shin et al. (2011) conducted a quantitative study aimed to examine the representation of diversity in admission and retention of students in counselor education programs. Shin et al. (2011) surveyed 85 counseling training programs accredited by different

accrediting bodies (CACREP, APA, and CORE). The findings of this study account for significant issues in the assessment of the representation of diversity in training programs. Shin et al. (2011) recommended increasing the representation of persons with disabilities and other marginalized identities in CACREP accredited programs, given that this represents "an important test in ensuring that these devalued and marginalized groups have voice within the counseling field" (p. 123). Furthermore, in terms of representation of identities in the counseling room and training programs, Shin et al.'s (2011) findings are congruent with Reeve's (2000) advocacy for the active and intentional inclusion of counselors with disabilities in the profession.

In short, the need for the infusion of disability content aimed to foster disability competence development in counselor training has been largely emphasized in the counseling literature. For instance, Lofaro (1982) stressed the silence of disability in the multicultural discourse and urged the profession to train "professional counselors in providing services and creating social change" (p. 206). Moreover, in congruence with Lofaro's (1982) recommendations for counselor sensitivity, skills and knowledge, the counseling profession has maintained growing commitments for social responsibility and human dignity by repositioning multiculturalism at the core of counseling pedagogy, practice, and research (Ratts & Pedersen, 2014). Therefore, these philosophical changes in the contemporary profession represent significant opportunities for more inclusive and socially just professional roles related to the provision of services to clients with disabilities.

Shifting Forces in the Disability Discourse

Medicalized and deficit-focused narratives of disability have been prevalent in traditional psychology (Olkin & Pledger, 2003) and counseling (Smart & Smart, 2006). These narratives have situated disability as a personal failure, biological inferiority, pathological descriptions, and

signs of abnormality (Davis, 2013; Shakespeare, 2013; Smart & Smart, 2006). These narratives

have pervasive, institutional, and systematic consequences leading to inferior or inadequate

service provision from counselors, and the generalized assumption that clients are responsible for

not reaching out, engaging in services, or overcoming personal difficulties to achieve optimal

levels of wellbeing (Smart & Smart, 2006). Even though early rehabilitation counseling

functioned in alignment to the biomedical model of disability (Pledger, 2003), the shifts in the

understanding of disability within the counseling profession has been evidenced in different

ways.

  Contemporary rehabilitation counseling. The discourse around disability has shifted

from a medicalized emphasis to rehabilitation approaches that recognize the social dimensions

that impact clients with disabilities through policy development (Pledger, 2003). In alignment

with more contemporary models of disability, which conceptualize disability as a social, cultural,

and political experience (Linton, 1998; Shakespeare, 2013), rehabilitation counseling has

increasingly positioned persons with disabilities as a historically marginalized group, vulnerable

to bias and discrimination as any other minority group based on race, ethnicity, social class,

sexual orientation, or religion/spirituality (O'Brien, 2011, Pledger, 2003). From this lens, the aim

is not to change or fix the individual, but to understand the person's cultural complex interplay

that explain psychological experiences in a disabling society (Reeve, 2006; Smart & Smart,

2006).

  For instance, Smith et al. (2008) emphasized the need to address ableism in counseling.

These authors described ableism as "a form of discrimination or prejudice against [people with

disabilities] that is characterized by the belief that these individuals need to be fixed or cannot

function as full members of society" (p. 86). Smith, et al. (2008) explained the negative effect of

ableism in society and further positioned rehabilitation counseling as a venue to address these issues in the provision of counseling services. Additionally, Smart and Smart (2006) described the different models that have shaped the conceptualizations of disability within counseling, and strongly advocated for the integration of disability models that account for the environmental and sociopolitical realities faced by people with disabilities.

Thus, even though rehabilitation was initially conceptualized as "the process by which physical, sensory, and mental capacities are restored or developed in people with disabling conditions" (Brandt & Pope, 1997, p. 24), this focus on deficit has shifted to "a strength-based approach that recognizes the capacity of individuals with disabilities to perform when optimal conditions exist within the environment" (Pledger, 2003, p. 281). Moreover, "clients are seen as being able to act and make decisions for themselves, as having agency or the capacity for control over themselves and their lives, if facilitated in a non judgmental way, within a supportive context" (Swain et al., 2006, p. 165). In short, the shifts in rehabilitation approaches have further aligned with affirmative and multicultural counseling commitments, which highlight social responsibility, client agency, and human dignity.

Galvanizing multiculturalism within counseling discourse and practice has influenced the ways in which diversity and cultural differences are comprehended and embraced by counselors. The presence of multiculturalism in counseling has fostered socially grounded descriptions of identity and social justice advocacy for minority clients (Ratts & Pedersen, 2014). Even though the advancements in multicultural and social justice discourse within counseling have evidenced the increasing acknowledgement of counselor self-awareness, client worldview, relational dimensions, and advocacy interventions in the counseling work with marginalized communities, these improvements are still emerging in relation to disability as a cultural identity within

counseling. Moreover, as evidenced in the latest version of the Multicultural and Social Justice Counseling Competencies (Ratts et al., 2016), the dynamism of multiculturalism in the counseling profession offers promising potential for shaping disability identity conceptualizations in counselor training.

Disability Studies. Disability studies discourse links the sociological, historical, anthropologic, political, law, and literary aspects of disability (Olkin & Pledger, 2003) and organizes a knowledge base that offers a socially grounded understanding of disability within multiculturalism (Linton, 1998). This approach places a greater emphasis on power, oppression, community identity, and civil rights (Olkin & Pledger, 2003) and situates disability as a public concern and a political act (Smart & Smart, 2006). According to Smart and Smart (2006), "a perfect world is not a world without disability, but a world in which accommodations and services are provided to people with disabilities, and, more important, disability is not viewed as inferiority" (p. 35). Informed by socially just and culturally responsive views of differently abled persons, social views of disability have helped reorient counseling service provision and training (Olkin & Pledger, 2003; Smart & Smart, 2006). In other words, the field of disability studies is a key factor influencing the shifts in the disability discourse within counseling.

Disability studies offer several theoretical claims that have contributed to shifting views of disability in counseling. First, even though the rehabilitation discourse has moved away from solely seeing clients with disabilities from a medicalized framework (Pledger, 2003; Smart & Smart, 2006), disability studies has further disarticulated the presentation of disability as a problem that creates significant limitations in the person's life (Linton, 1998; Shakespeare, 2013). This shift promotes more human, contextualized, and socially just conceptualizations of disability within counseling. One example of this influence has led to the abandonment of

medicalized narratives that further pathologize clients' experiences within the profession (Ratts & Pedersen, 2014) and as it seeks to embrace and affirm all forms of diversity (Hill, 2003; Ratts & Pedersen, 2014).

Second, in congruence with the disability rights mantra "Nothing About Us Without Us" (Charlton, 1998), disability studies highlights the importance of disability subjectivities by recognizing the uniqueness of cultural experiences related to disability and by including first account narratives from people with disabilities (Charlton, 1998; Linton, 1998; Shakespeare, 2013). Even though the counseling profession strives to affirm diversity, issues related to the representation of minority identities in admission and retention (Shin et al., 2011), and lack of research and scholarship still remain (Olkin & Pledger, 2003). Nonetheless, highlighting and representing individuals with disabilities through all realms of the profession aligns with espoused values of multiculturalism and social justice.

Third, the multicultural force within the counseling profession has advanced an intersectional discourse that accounts for the interplay of multiple social markers in people's lives (Ratts & Pedersen, 2014). However, the impulse to objectify and essentialize disability in counseling persists (Reeve, 2000; Smart & Smart, 2006). These understandings of disability are based on modernist and medical assumptions of health and functionality (Davis, 2013; Linton, 1998). Disability studies focuses on the social response to disability as an organizing experience that determines psychological, social, political, academic, occupation, relational, and material consequences for disabled clients (Shakespeare, 2013). For instance, people with disabilities' experiences of societal bias and discrimination become an organizing framework that defines access and opportunities. A disability studies approach to the lives of people with disabilities is

congruent with the current version of the multicultural and social justice competencies (Ratts et al., 2016) in that it seeks to address the intersectional and the social rather than the individual.

Fourth, even though the counseling profession is increasingly moving towards the recognition of community and systemic factors impacting the lives of clients (Ratts & Pedersen, 2014), there still exists an overemphasis in counseling interventions aimed at the individual level. Disability studies offer a perspective that informs a multidimensional focus of action for counselors. Specifically, disability studies consider the changes in the person's context as a valuable aspect of the individual work with clients with disabilities (Shakespeare, 2013). This potential for context change and advocacy also aligns with newer versions of multicultural and social justice advocacy competencies for counselors (Ratts et al., 2016). Thus, disability studies not only blends into multiculturalism within counseling, but it adds a productive force that offers new ways to think about the interactions with the multicultural community.

Fifth, in response to the political nature of professional diversification within counseling in the U.S., disability has traditionally been associated with rehabilitation counseling (Smart & Smart, 2006). Disability is not typically infused across the general counselor curriculum (Reeve, 2000; Smart & Smart, 2006; Smith et al., 2008), but rather marginalized to specific lectures within multicultural education (Pieterse et al., 2009). Linton (1998) defined the development and infusion of disability knowledge and competence throughout all areas of professional education as an "epistemology of inclusion" (p. 135). Approaches that assert disability as a privileged identity within multicultural education foster the disruption of marginalizing views of disability and seamlessly align with professional values of affirmation of diversity and social justice.

Newer disability studies approaches such as critical disability studies further conceptualize disability beyond discrete definitions of human variation covered by

multiculturalism and beyond binary ways of thinking about disability as being something

medical or social (Meekosha & Shuttleworth, 2009). These emerging approaches have

heightened potential for further informing disability perspectives in multicultural counseling

discourse. However, I was not able to locate any literature regarding the ways critical disability

studies might inform the practice of counseling or the overall counseling profession.

In conclusion, the professional practice of counseling is rooted in medical and

rehabilitation views of disability, yet emerging disability discourses are beginning to influence

counseling (Smart & Smart, 2006). These emerging discourses situate disability as a social event

with historical, political, and psychological implications for clients with disabilities (Reeve,

2000, 2006; Smart & Smart, 2006; Smith et al., 2008) and amplify the grounds of action for

professional counselors. Disability studies precepts can further inform counselors' multicultural

practices by facilitating the recognition of the elusive psychological elements of disablement,

and deconstructing and promoting socially grounded knowledge about disabled identities. This

knowledge can stimulate multicultural activism through professional practice, the

acknowledgement of identity interstices interplay, the transformation of mental health

institutions, and the promotion of socially just counseling practices (Lawthom & Goodley,

2006).

Although there is no clear definition of what disability competence is, nor its indicators, it

is possible to show how it is related to overall multicultural competence. The constructs and

literature emerging from rehabilitation and disability studies have identified potential factors that

may inform the development of disability competence for practicing counselors. Moreover, from

a review of the literature, disability competence could be grounded in psychological dimensions

of disablement (Reeve, 2000), multicultural skills (Sue et al., 1992) and social justice advocacy

(Ratts et al., 2016). Disability competence could also be informed by the recognition of social context (Smith et al., 2008; Smart & Smart, 2006), as well as the recognition of the sociopolitical dimensions of disability in the counseling work (Reeve, 2000, 2006). Next, I expand the arguments related to the disability competence enacted in the multicultural practice of licensed professional counselors, as well as the scholarly needs that informed this research study.

Disability Competence Enacted in Multicultural Professional Practice

The 2015 multicultural competencies endorsed by AMCD and ACA establishes a set of guidelines for counselors to enhance counseling theory, practice, and research; to highlight intersecting aspects of cultural identity; and, to recognize and address dynamic forces related to power, privilege, and oppression that impact the counseling relationship (Ratts et al., 2016). The main body of multicultural competence research has been concentrated in the training of counselors, and little is known about the further development or enactment of these competencies in the clinical practice of graduated counselors (Dodson, 2013; Moss et al., 2014). Moreover, when the enactment of multicultural competence by graduated counselors has been examined, authors have found inconsistencies in their findings.

For instance, Dodson (2013) found that professional counselors from dominant identities reported higher levels of multicultural awareness and scored higher in multicultural competence compared to their peers who identified with a marginalized racial identity. Dodson's findings contradict Vinson and Neimeyer's (2000) assertion that professional counselors with marginalized racial identities conveyed more advanced levels of racial identity development that correlated with higher levels of multicultural awareness and competency. Furthermore, there is a dearth of research pertaining to the enactment of disability competence by licensed professional counselors.

CACREP (2016) has outlined standards to guide the training and professionalization of counselors in a variety of tracks, including clinical mental health and community counseling. As previously stated, the standards refer to a number of core dispositions that encompass social and cultural diversity training and which need to be evidenced through student learning outcomes by accredited counseling programs (Foster, 2012). Specifically in terms of multiculturalism, counselors are expected to have an enhanced understanding of the cultural context of the counseling relationship, issues that might bring the client to counseling, and the ways that those in the profession should respond to the multicultural needs of the client (CACREP, 2016). Moreover, even though disability is integrated in the core area of social and cultural diversity within CACREP standards, there is a dearth of research that documents the professional counselors' enactment of disability competencies that account for contextual aspects in the work with disabled clients.

Specifically, in terms of clinical mental health counseling, CACREP (2016) requires programs to ensure the learning of cultural dimensions relevant to the practice of clinical mental health counseling (5.C.2.j.), and to integrate strategies to advocate for persons with mental health issues (5.C.3.c.). However, there is a lack of research related to defining or exploring the ways licensed clinical mental health counselors further develop multicultural competencies learned in training or how these competences are demonstrated in working with clients with disabilities. Hence, there is a dearth of literature regarding the specific processes and domains that interact in the development and enactment of multicultural competence related to disability in clinical mental health settings (Olkin & Pledger, 2003).

Additionally, after completing a standardized training, a set amount of supervised clinical practice, and passing a knowledge-based test, licensed professional counselors are assumed to be

competent in working with diverse clients, including clients with disabilities. However, not much is known about their process and individual descriptions of the development of disability competence. Moreover, given that disability is a less emphasized area within the multicultural curriculum (Smart & Smart, 2006; Smith et al., 2008; Reeve, 2000), that disabled people are still engaging in counseling services every day (Smart & Smart, 2006; SAMHSA, 2014), and given the historical factors and political antecedents related to disability in the U.S., it is important to bring to light through scholarship the ways in which licensed professional counselors' multicultural knowledge, awareness, and skills interact with and develop when engaging clients with disabilities in the counseling process.

Holcomb-McCoy and Day-Vines (2004) stressed the importance of exploring multicultural development and competence among professional school counselors though qualitative inquiry. Likewise, I consider it is imperative to understand the complexities of the processes that lead to the development of disability competence within the multicultural practice of licensed professional counselors. In the following and final section of this chapter, I further expand my arguments and rationale for using qualitative inquiry and grounded theory tradition to address my research questions.

Rationale for Qualitative Methodology

Corbin and Strauss (2015) situated qualitative research as a form of inquiry that entails the researcher's collection and interpretation of data about a phenomenon in context, which is focused on the qualities of the constructs, processes, and meanings built by the participants. Moreover, qualitative research tends to be exploratory and positions questions as why or how to examine aspects or different angles of a phenomenon (Hays & Singh, 2012). Thus, qualitative inquiry was selected for this study as it affords the opportunity to explore the intricacies of

disability competence as a phenomenon and describe the individual processes from participants perspectives or point of view.

Along with Holcomb-McCoy and Day-Vines' (2004) arguments for qualitative inquiry, Vereen et al. (2008) further asserted that qualitative inquiry allows the researcher "to see how multifaceted components of engaging in clinical experiences of diverse clients specifically impacts competence" (p. 235). These assertions about qualitative inquiry are meaningful to the examination of multicultural development related to disability competence, inasmuch as qualitative research affords rich descriptions of participants' experiences about complex, simultaneous, and multidimensional processes emerging in their clinical practice. Thus, this study examined the process of the development of disability competence of licensed professional counselors through the qualitative co-construction of a theory grounded in the participants' descriptions of this phenomenon.

The main purpose of using qualitative research was to gather participants' rich descriptions of their experiences, while fostering the emergence of general concepts and theoretical explanations of disability competence that could offer new insights into the dynamics and processes that constitute counselors' experience working with clients with disabilities (Corbin & Strauss, 2015; Hays & Singh, 2012). Moreover, grounded theory "holds at its core the construction of theory out of lived experiences of participants, and as such, it integrates theory and practice in ways that few other approaches can boast, constituting a methodological exemplar of the scientist-practitioner model" (Fassinger, 2005, p. 165). In other words, theory is situated and grounded in social and cultural contexts specific to the participants. Thus, study sought to answer questions related to the process of the development of disability competence in

licensed professional counselors through the use of grounded theory as a methodological tradition.

Grounded theory has been widely used within counseling and counseling psychology research. Moreover, the inductive nature of this tradition parallels clinical reasoning because (Fassinger, 2005; Hays & Singh, 2012). For instance, grounded theory has been used within multicultural counseling and social justice change (Berry, 2013; Hipolito-Delgado, Pharaoh, & Hermosillo, 2016; Singh, Urbano, Haston, & McMahon, 2010), gender identity development (Edwards & Jones, 2009); gatekeeping (Ziomek-Daigle & Christensen, 2010); and professional identity development (Gibson, Dollarhide, & Moss, 2010; Moss et al., 2014). The use of grounded theory in this study afforded increased attention to the processes involved in the development of competence to work with clients with disabilities, which occurs in the practice of licensed professional counselors who work with clients with disabilities. The illumination of these processes amplified the opportunities to enhance counselor training, professional standards, and social justice advocacy. The following Chapter III describes the proposed methodology in greater detail.

Chapter III: Methodology

Introduction

One billion people around the world and 19.8 million people in the U.S. (Brault, 2012; World Health Organization, 2011) have a disability. As the largest minority group, the demand for counseling services responsive to individuals with disabilities in communities around the country remains a pressing issue for the profession. The counseling profession in the U.S. has responded to the service needs of this minority group by integrating disability as an aspect of multiculturalism within the preparation of professional counselors (CACREP, 2016; Olkin, 1999; Olkin & Pledger, 2003; Reeve, 2000; Smart & Smart, 2006). The relevance of including disability as an aspect of multiculturalism in counseling is demonstrated by the recent creation of Clinical Rehabilitation Counseling as a new specialty within counseling programs accredited by CACREP (CACREP, 2016). Even though disability has been included as a nominal content of multiculturalism in counseling, its representation in pedagogy, clinical practice, and research has remained largely silent (Swain et al., 2006). The minimal study of disability competence has been mostly situated in the multicultural training of pre-service counselors (Sheaffer, Sias, Toriello, & Cubero, 2008; Watt et al., 2009) and is one of many aspects of multiculturalism that has not been studied in terms of the practice of licensed professional counselors (Dodson, 2013).

Moreover, the literature that does exist usually stresses pre-service counselors' lack of disability competence. Specifically, different authors (i.e., Olkin & Pledger, 2003; Reeve, 2000; Smart & Smart, 2006; Smith et al., 2008) have remarked on counselors' difficulties in conceptualizing social dimensions of disability and engaging clients through the provision of appropriate services. These conceptualization difficulties about disability have been documented mainly in literature regarding counselors in training. Thus, given that licensed professional

counselors provide services to this population, it is important that this gap in the literature be addressed by exploring the processes whereby practitioners can describe their own development of disability competence.

This study sought to address this research gap by conducting a qualitative inquiry with licensed professional counselors aimed at exploring how they developed disability competence post-licensure. Specifically, this study aimed to illuminate the complexity of processes, properties, and dimensions related to the development of disability competence for licensed professional counselors through qualitative inquiry. Illuminating these processes will contribute to a better understanding of how disability competence could be infused in counselor preparation and improve multicultural practice for licensed professionals (Reeve, 2000; Smart & Smart, 2006; Swain et al., 2006), as well.

Qualitative Methodology

According to Corbin and Strauss (2015), qualitative research is a form of inquiry that entails the researcher's collection and interpretation of data about a phenomenon in context. The data for this study focused on the qualities of the constructs, processes, and meanings of disability competence as constructed by participants (Corbin & Strauss, 2015; Lincoln & Guba, 1985). Qualitative research tends to be exploratory and positions questions as "why" or "how" to examine aspects or different angles of a phenomenon (Hays & Singh, 2012). This qualitative inquiry thus aimed to explore how the development of disability competence occurs in licensed professional counselors.

Moreover, in qualitative inquiry, the researcher is considered an instrument of the research process who becomes immersed in the data, the setting, and the process of analysis from the beginning of the study (Corbin & Strauss, 2015; Hays & Singh, 2012). According to Corbin

and Strauss (2015), qualitative researchers have the opportunity "to connect with their research participants and to see the world form their viewpoints" (p. 5) while engaging in the research inquiry with curiosity about the world and demonstrating commitment to "improve the social conditions or lead to social change" (p. 5). The intention of becoming immersed in the data and striving for deep understandings of the participants' descriptions are signature tasks of the qualitative researcher, which require an ability for reflexivity and awareness of the power transactions behind knowledge production (Barinaga & Parker, 2013; Hays & Singh, 2012).

The purpose of this study was to uncover the processes related to the development of disability competence in licensed professional counselors. Therefore, the guiding research questions for this qualitative study were:

1) How do licensed professional counselors develop competence to work with clients with disabilities?

2) What does disability competence look like in terms of counselors' self descriptions of practice? And,

3) What are the similarities and differences of disability competence compared to multicultural competence?

Compared to other qualitative traditions, grounded theory uncovers the core process within a certain phenomenon and describes its underlying dimensions of development. For this reason, grounded theory was chosen as the qualitative methodological tradition as it was deemed the most appropriate approach to answer the research questions in this study.

Grounded Theory

Grounded theory has the purpose of generating a theory that fundamentally emerges from the participants' experiences with a particular phenomenon of interest (Corbin & Strauss, 2015;

Hays & Singh, 2012). According to Corbin and Strauss (2015), this tradition "allows for [the] identification of general concepts, the development of theoretical explanations that reach beyond the known, and offers new insights into a variety of experiences and phenomena" (p. 6). Grounded theory offers the possibility to explore the world from the descriptions of the participants' point of view in a reciprocal relationship between the researcher, the data, and the creation of a theory about the phenomenon.

Corbin and Strauss (2015) identified a variety of unique features of this methodological tradition. First, grounded theory "is constructed [from concepts that] are derived from data collected during the research process and not chosen *prior* (authors' emphasis) to beginning the research" (p. 7). As this tradition seeks to move from simpler to more complex constructions of the theory about the phenomenon, research using grounded theory situates a research question in the existing literature with the intention to find potential explanations of the process as the participants view it (Corbin & Strauss, 2015; Creswell, 2013; Hays & Singh, 2012). Even though this tradition does not require an extensive review of the literature, the researcher goes back to the literature as the theory is generated (Hays & Singh, 2012). Specifically in this study, I was interested in exploring potential explanations of the process of disability competence development in licensed professional counselors, as they viewed it.

Second, another feature of grounded theory is the reciprocal nature of the analysis and collections of data through a process of constant comparison between the interactions with the participants and the evolving analysis (Corbin &Strauss, 2015). In this research tradition, the researcher is involved in a procedure that Creswell (2013) considers a "zigzag process" (p. 64) inasmuch as the researcher goes out to the field to gather information from the participants, into the analysis of the data, back to the participants to collect more information, back to the analysis

of the data, and so forth until saturation is reached. This constant comparison "serves as the basis for theory development" (Hays & Singh, 2012, p. 49) and affords the researcher the process to strive for complexity in the construction of theory.

Specifically in this study, my role as a researcher entailed the engagement in this comparative process from the participants' description, to the analysis of the data, back to more participants' descriptions, and so forth, until I had uncovered the core categories of the phenomenon as the participants experienced it. Additionally, grounded theory offers several benefits such as a high degree of structure in the process of data collection and analysis, the possibility to gather large amounts of data, and the focus on the researcher's role and subjectivity in the process (Hays & Singh, 2012).

Grounded theory was heavily influenced by the epistemological trends during the time of its emergence; pragmatism and interactionism laid the foundation for this methodological tradition. However, contemporary philosophical ideas have also influenced it and defined how this methodology is currently used (Corbin & Strauss, 2015). As grounded theory has evolved to respond to contemporary postmodern thought, it has sought to integrate "interpretive methods more deeply into the regions of postmodern sensibility" in specific ways (Corbin & Strauss, 2015, p. 25). For instance, the initial conceptualization of grounded theory has moved from the emphasis on one reality waiting to be discovered to a constructivist notion of external events that are constructed, subjective, and created through transactions with the environment (Corbin & Strauss, 2015; Lincoln & Guba, 1985). Given that context matters in the multicultural practice of professional counselors who are developing disability competence, grounded theory affords a constructivist, subjective, and contextually informed creation of a theory about this phenomenon.

Constructivist perspective of grounded theory. According to Lincoln and Guba (1985) and Hays and Singh (2012), the immersion of the researcher in the research process offers new perspectives and a different level of engagement with the data and the analysis. These enhanced perspectives afford more opportunities for the truthful construction of knowledge that is grounded in the closeness of the researcher to the issue of study. I honored Corbin and Strauss' (2015) constructivist framework by grasping my participants' views of the phenomenon while bringing myself as a researcher into the study in a way that my values, life experiences, and subjectivity were all a part of the research process. This constructivist perspective served as the foundation for my data collection, analysis, and overall engagement in the research process. One of the ways I enacted this was through the use of interpretive dialogue interviews (Clarke, 2005) where I worked to facilitate shared and co-constructed meanings of the descriptions with my participants in an atmosphere of collaboration.

Feminist perspective of grounded theory. Corbin and Strauss (2015) further aligned with feminist thought and situate the meaning given to events as they occur in a political, historical, and material context. These authors state, "each person experiences and gives meaning to events in light of his or her own biography or experiences, according to gender, time and place, and cultural, political, religious, and professional backgrounds" (p. 25). In this sense, the tradition of grounded theory has evolved to recognize the complexities of power dynamics in human relations that determine the conditions for different groups.

Contextualizing this evolution of grounded theory within the counseling profession, and given that this study entailed marginalized identities in the personhood of the researcher and the area of study (disability), this study aligned to Corbin and Strauss' (2015) responsiveness to contemporary epistemology in multiple ways. First, this study attended to contextual aspects of

participants' accounts and descriptions, based on some intersectional aspects of identity as well as the personal constructions of worldviews based on positionality (Sim Chun & Singh, 2010). This was accomplished by attending to social markers in the participant's demographic questionnaires, and bringing them into the interviews as potential factor informing the work as professional counselors. I also attended to contextual aspects of participant's descriptions by highlighting the complexities of the counseling work when clients with disabilities experience the impact of culturally related stressors. Therefore, this feminist approach was evidenced in my genuine interest to grasp the complexities of the participants' descriptions through interview questions aimed to unpack personal accounts of their worldviews. These contextual and enriched descriptions were further facilitated by the completion of member check interviews in the form of interpretive dialogues, which enhanced the level of collaboration in the construction of knowledge.

Second, this study examined and embraced the intricacies of power in the development of disability competence. This was evidenced by my intentional questions and prompts aimed at unpacking the layers of power transacted around counselors serving people with disabilities and on myself as a researcher obtaining these descriptions from professional counselors. I also attended to the transactions of power around the construction of descriptions during the interviews by summarizing and checking for accuracy of accounts throughout the interviews and later through the use of interpretive dialogue interviews with each participant at different moments of the collection of data.

Finally, this study aligned with Corbin and Strauss' (2015) feminist intentionality to "bring about social change and make persons' lives better" (p. 27) as well as with the feminist aspects of disability studies as a critical lens. Such an activist stance was fostered by creating a

theory as it was seen by the participants and which was aimed to inform the counseling

profession about the specific aspects and processes involved in the development of disability

competence after graduation and post-licensure. The implications of these descriptions and the

co-construction of this theory can potentially bring change that could improve the nature of

training and service of this minority.

Researcher Role

In qualitative research, the researcher is "as much a part of the process as participants and

the data they provide" (Corbin & Strauss, 2015, p. 3). This makes it necessary that the research

process and overall analysis are understood in relation to the researcher's ability for reflexivity

and negotiation of power in the relationship with the participants and in the process of

knowledge production. As a researcher, I brought my own set of assumptions, biases, and

worldviews into the research process (Corbin & Strauss, 2015). Because of this, Hays and Singh

(2012) emphasized the need for reflexivity in the researcher throughout the research process. The

impact of my views and perspectives was manifested "in the meaning given to data, the concepts

used to stand for that meaning, the questions that are asked, and the comparisons that are made"

(Corbin & Strauss, 2015, p. 46). Specifically, as a researcher in a grounded study, if unchecked,

these factors could have influenced my ability to build relationships with the participants, in my

constant comparison between data and analysis, as well as in my interpretations of propositions

that will define a larger theory about the phenomenon.

My reactions and interpretations of the data also represented opportunities for enhanced

theory construction given that these were handled in a way that was reflexive, increased the

trustworthiness of the findings, and enhanced the overall strength of the design. Even though

reflexivity has become the signature feature of trustworthy qualitative processes, its enactment

goes beyond doing and is situated in a way of being throughout the research process (Hays & Singh, 2012). Within counseling research, a heuristic device to enhance reflexivity is to define positionality in terms of the researcher being an insider or outsider of the phenomenon in study (Hays & Singh, 2012).

Whereas insider is defined as the researcher who has knowledge of the phenomenon prior to the initiation of the study and an outsider is defined as the researcher who has no prior intimate experience with the participants or the phenomenon studied (Hellawell, 2006; Hays & Singh, 2012), I believe in the benefits of moving beyond dichotomous descriptions of identity and defining the complexities of my otherness through my claimed positionality. According to Hays and Singh (2012), positionality refers to the social locations of the researcher and participants, as well as the acknowledgment of the dynamics that determine how power is distributed in the researcher process and in the construction of knowledge.

Researcher Positionality

My positionality is partly informed by Western perspectives of mental health, disability, and wellness given my training and professionalization as a mental health counselor in the United States. In this sense, I am an insider to narratives of Western counseling training and practice in a Northern context that values best practices, therapeutic objectives, and diagnoses. Though I pass as an insider in this professional identity, I am fundamentally an outsider to the Northern and American context given that I am originally from South America (Hellawell, 2006; Hays & Singh, 2012). This blended positionality affords me the privilege of experiencing different angles to the mental health profession that inform who I am as a pre-licensed counselor and a scholar. Given the privileges I represent because of my education level and middle-class status, it is not my intention to speak for my participants or to construct a theory about disabled

and third world communities. I believe in the power of using my flexible positionality along with my other privileges to access audiences and build collaborations that represent opportunities for mental health and wellness for all. Moreover, being an able-bodied bilingual researcher affords me the opportunity to reach a broader audience.

I am a cis-gender, able-bodied female who was raised in a lower-middle class Latino and Spanish speaking family in South America. I completed my basic and secondary schooling in Ecuador, immigrated to Venezuela where I graduated as a bachelor-level psychologist, and later immigrated to the United States to learn English and complete my graduate studies as a counselor and counselor educator. Immigration and rootlessness have heavily informed my cultural identity and have made me aware of the unearned privileges and oppressions from diaspora. Moreover, as a researcher aligned with Corbin and Strauss' (2015) constructivist and feminist commitments in grounded theory, I was committed to continuously examining how my work might perpetuate misrepresented and marginalizing views of others. Thus, I tried to remain mindful of this risk and aimed to frame my qualitative findings based on my complex identity configuration that informed my lens as a researcher.

Researcher's feminist and critical disability studies perspective. My lens as a researcher was strongly informed by critical disability studies, which embraces feminist views of myself and the world. These theoretical views mainly informed my positionality in how I understand and conceptualize disability. In counselor training, disability is typically conceptualized according to the CACREP standards' (2016) definition of identities within multiculturalism. Among other cultural identities, multiculturalism also entails clients with different physical, emotional, and mental abilities. As a researcher also informed by disability studies field of study, disability was further defined in this study as a variety of sensory,

physical, and mental health labels that can be "experienced differently depending on cultural contexts, social class, race, and gender" (Annamma, Connor, & Ferri, 2016, p. 27). Moreover, Corbin and Strauss (2015) stressed the importance to understand the research constructs in context, then disability in this study was conceptualized in its intersection with other contexts of identity when examining how the participants' social world is constructed (Annamma et al., 2016; Sim Chun & Singh, 2010).

While I intentionally used the term disability to denote an identity that includes people who have been historically situated in a complex variety of impairment groups that include physical, learning, sensory, cognitive, and mental health issues (Goodley & Lawthom, 2006), I also interpreted disability as a social construct that "derives meaning and social (in)significance from the historical, cultural, political, and economic structures that frame social life" (Erevelles & Minear, 2010, p. 132). I also believe that social constructions of disability shape the lived experiences of a significant amount of people within the US and around the world (Meekosha & Shuttleworth, 2009).

I believe that as a cultural practice, professional counseling involves the use of language, social constructs, and other byproducts of the cultural world that relate to historical, cultural, and political conceptualizations of mental health and disability. Therefore, I believe that as counselors, "when we speak of, label, react to, deal with, joke about, medicalize, professionalize, rehabilitate, drug, treat, think of or relate to impairment, we reveal its fundamentally social nature" (Goodley & Lawthom, 2006, p. 3) that pertains to multicultural competence. Even though disability has not received this emphasis consistently within the multicultural education of counselors, I sought to further entrench intersectional aspects of disability in the counseling discourse by representing the disabled body and mind as no longer biological only but as the

embodiment of social relations (Meekosha & Shuttleworth, 2009), and situating disability as the organizing ideological force that defines social hierarchies (Erevelles & Minear, 2010).

In summary, my emphasis on the sociopolitical and contextual aspects of disability in this study detached from a rehabilitation view of impairment and was rooted in a critical paradigm of disabled subjectivities. This emphasis separated from the individual realities of disability in the counseling engagement and relationship and shifted towards the construction of a theory that sought to look at the social processes and cultural forces within the profession that inform the development of disability competence of licensed counselors. Furthermore, this study positioned disability and impairment as complex events impacting the lived experiences of many people, which are fundamentally grounded in social constructions of health and normalcy. My intention was to bring together counselor education and disability studies in a way that affirmatively enhances the understanding how counselors engage with the complexities of disabled people's lived experiences.

Strategies to Address Subjectivity

I was forthcoming about my reflexivity as a researcher through the implementation of different strategies that are explained later in this chapter. Some of these strategies entailed the consistent use of memos and reflexive journals, participant checks in the form of interpretive dialogues (Clarke, 2005), the consensus on the research team about the interpretation of findings, triangulation of data, and peer debriefing (Hays & Singh, 2012). As a researcher, I had a commitment for deep reflection, introspection, and awareness of my positionality in the process of documenting and understanding my participant's experiences, as well as in the process of theory construction.

Procedure

As grounded theory is often used across disciplines, there are several ways to approach it methodologically (Hays & Singh, 2012). However, for the purpose of this study, I defined a procedural approach that honored the main precepts of this tradition as it is conceptualized by Corbin and Strauss (2015), that was consistent with its use in counseling research, and which guaranteed sustained immersion and engagement in the data in the construction of theory. Given that in grounded theory the research process initiates from the immersion in the literature and the definition of the research question (Corbin & Strauss, 2015), as a researcher, I situated the existing literature and research question as the framework to advance to the collection of data. Specifically, I used qualitative semi-structured interviews and interpretive dialogue interviews to build the relationship with my participants and to obtain direct accounts of the descriptions of their experiences. Thus, along with the comparative process and continuous coding, the research design in this study was strengthened through sustained reflexive engagement captured through memos and journaling, peer debriefing, and data triangulation.

In total, twenty participants engaged in the entirety of the research process, which involved four separate contact points with each participant: two interviews and two interpretive dialogue interviews. Licensed professional counselors who graduated from CACREP accredited programs and were currently seeing clients with disabilities were invited to participate in this study upon approval from the Institutional Review Board (IRB) of the researcher's university. See Appendix B for Syracuse University's IRB approval letter.

Once the process of data collection started, I read through the transcripts as I completed each interview and started the recursive process of coding and going back to obtain more data (Hays & Singh, 2012). As this cycle repeated and fueled the interpretive nature of the research

process, I worked to identify large codes that were constantly informed by new sets of data. This constant comparative process allowed me to search for similarities and differences, as well as underlying uniformity in the emerging codes. Moreover, as these codes were compared and refined, I worked to arrive at more specific and comparative concepts and properties of the phenomenon studied (Corbin & Strauss, 2015; Hays & Singh, 2012). Specifically, I constantly compared previous interviews and analysis to subsequent interviews and analysis throughout the research process.

Following Corbin and Strauss' (2015) process of analysis, I became immersed in my participant's descriptions and continuously strived for the integration of emerging conceptual pieces related to their development of disability competence as licensed professional counselors through each round of interviews and interpretive dialogues. The data was collected in two rounds of interviews with subsequent interpretive dialogue interviews. These interpretive dialogue interviews helped me increase collaboration with participants and expanded the interpretive power of the analysis, as each participant had the opportunity to confirm, disconfirm, adjust, and expand the evolving analysis based on their experiences with the phenomenon (Clarke, 2005). The use of interpretive dialogue interviews not only helped me expand and add complexity to the emerging analysis based on the participants' feedback, but it also fostered my research relationships with the participants, increasing their level of trust and investment in the descriptions of their experiences. These enhanced benefits added important value to this strategy that moved from member checking to collaborative research engagement (Clarke, 2005; Hays & Singh, 2012).

In summary, I worked to identify a qualitative grounded theory that was co-constructed with my participants based on their experiences with the phenomenon. This emerging theory

illuminated the ways in which licensed professional counselors understand and experience their development of disability competence. I further worked towards theory formulation from the participants' experiences, and remained mindful of the impact of my own positionality in the process.

Participants

Twenty-one participants were recruited for this study; however, twenty engaged in all phases of the data collection. Thus, the formal sample of participants in this study included twenty licensed professional counselors (LPC, LPCMH, LMHC, LCMHC, LCPC) who had a counseling relationship with at least one client with an identified disability, who had held a counseling license for around 1 to 10 years, and who had worked in community clinics, schools, higher education or private practice settings. An identified disability in this study was defined as the presence of physical, developmental, cognitive, and sensorial conditions that significantly impacted daily functioning (occupational, educational, relational), that were aware to the client, and that might have granted the access to government assistance in the form of SSI or to an IEP. Through the process of recruitment, the types of disability present in the participants' clinical experiences were assessed to guarantee maximized variation of sampling.

The recruitment of participants initially focused on the North Atlantic region of ACES (NARACES). The states included in this region are: Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, District of Columbia, Puerto Rico, and Vermont. Given the recruitment needs, the state focus increased and other ACES regions were considered. To ensure confidentiality, pseudonyms chosen by the participants were used during the research process and in the written analysis to protect the anonymity of their identities.

For the purpose of this study, counselor licensure was defined "as the most inclusive type of credential, which is usually legislatively based, limits the use of a particular title and protects the right to practice" (Foster, 2012, p. 47). Foster (2012) explained that whereas the requirements for professional counseling licensure vary across states, the basic licensure requirements entail holding a master's degree from a regionally accredited institution, a number of years of experience, as well as passing a performance examination created by the National Board of Certified Counselors (NBCC). Even though there is some variance in the licensure title awarded to professional counselors who meet the requirements, successfully passing a nationally standardized exam is considered a common aspect (Foster, 2012). Each state across the US regulates the requirements for maintaining a professional counseling license through state licensing board. Additionally, the licensed professional counselors in this sample had completed their training in programs accredited by CACREP. The table in Appendix A is an adaptation of an ACA (2016) publication about licensure requirements throughout the country, and defines the specific licensure requirements for each of the states within NARACES. Moreover, given that through professional connections one participant was recruited from North Carolina, this state is also included.

The length of professional engagement decisions in this study was informed by the sampling procedures of Moss et al., (2014) where they divided the groups based on years of experience: novice (1-2 years of experience), experienced (5-15 years of experience), and expert (20+ years of experience). The time of licensure selected for this study was 1 to 10 years. The rationale for this study's timeframe corresponded to a requirement of years that would potentially exceed the experience of a novice counselor and would suffice to be considered an early-experienced counselor. Moreover, by situating the amount of experience around the early

years of licensed professional practice, this study sought to potentially build connections with counselor training, which has not likely happened too long ago for the participants.

Participants were selected through purposeful sampling, which required the definition of specific criteria for participation prior to the beginning of the study (Hays & Singh, 2012). For the purpose of theory development, snowball sampling is usually considered the most appropriate convenience sample strategy that affords quick access to the population studied and the possibility to sequentially build (racial, expertise, language) variation and representativeness, as the participants are recruited (Hays & Singh, 2012). Thus, the procedure for obtaining my sample consisted of using public repository of licensed professional counselors' information available in the websites of the Departments of Licensing and Labor of the states considered, as well as extending a research invitation to alumni listservs from different CACREP accredited programs.

Participants working in the capacity of professional counselors of clients with disabilities were initially contacted through email or phone call. Once these participants agreed to participate and established contact with the researcher, the informed consent and demographic questionnaire was emailed for the participant to complete them before engaging in the first interview. Once the participants engaged in the relationship-building process throughout the initial interview, I asked if they knew and could refer other counselors who met the criteria. If they did, I facilitated the participant a research invitation to be extended to other potential participants.

Given the dearth of literature related to the development of disability competence during professional practice, and in congruence with Corbin and Strauss' (2015) emphasis on the contextualization of participants' personal constructions about their experiences with the phenomenon, I was intentional in co-constructing a theory considering the contextual and

cultural aspects of my participants. Thus, I strived for selecting a diverse group of licensed professional counselors who described the development of disability competence and that represented a variety of cultural identities.

This study entailed the use of a brief demographic questionnaire that was completed by the participants before the first interview. This brief demographic questionnaire included information about participants' race, ethnicity, gender, language, age, sexual orientation, dis/ability, years of practice, counseling practice setting, and number of clients with disabilities. This questionnaire was used to illuminate the analysis based on the variation in the configuration of social markers and cultural identities present in the group of participants. Refer to Appendix C for an example of the demographic questionnaire.

Data Collection

During the end of the Fall semester 2016 and the beginning of Spring 2017, two rounds of semi-structured interviews and interpretive dialogue interviews with twenty participants were conducted to understand their process of disability competence development as licensed professional counselors. Prior to completing the demographic questionnaire and engaging in the interview process, the participants reviewed and signed a research informed consent. By reviewing and signing the IRB approved informed consent form, the participants confirmed their agreement to participate in the interviews while having their identifiable information masked. Refer to Appendix D for the IRB approved participant informed consent form.

Semi-structured interviews "typically use an interview protocol that serves as a guide and starting point for the interview experience" (Hays & Singh, 2012, p. 239). In this study, I engaged my participants in a way that fostered intentional areas of questioning as well as the necessary openness for the full exploration of the phenomenon as they experience it. Further, the

participants were engaged in interpretive dialogue sessions following each semi-structured interview. Data collection was conducted only in English, through phone call or computer-based communication (Skype or Facetime). Data was audio recorded and transcribed.

The interview questions were initially organized in three areas of qualitative exploration. The first area related to participant's descriptions of experiences working with clients with disabilities. Given the paucities in disability training and the documented silence of disability as an aspect of diversity within the multicultural training of counselors, (Olkin & Pledger, 2003; Reeve, 2006; Smart & Smart, 2006; Swain et al., 2006; Watt et al., 2009) the first interview questions aimed to explore the descriptions of the participants' contact with this marginalized group. This first area of exploration within the interview included questions such as "How would you describe your experiences counseling people with disabilities?" "What have been the facilitating/meaningful factors for you personally and professionally when counseling clients with disabilities?" "What have been the challenges/most difficult aspects you have encountered personally and professionally when counseling clients with disabilities?" and "What has been the process of handling these facilitating factors/challenges as a licensed professional counselor?" Follow-up prompts to these initial questions included, "What kinds of disability have you encountered in your practice?" "What have you learned about this population as a licensed counselor?" "Can you recall a remarkable or critical experience that reflects this?" and "What factors, supports, resources have been involved?"

The second area of exploration during the interview related to the participant's descriptions of current level of competence to work with clients with disabilities. Given that counselors have the potential to engage clients with disabilities and address their counseling needs only if perceiving themselves as trained and competent (Swain et al., 2006), this set of

questions aimed to understand participants' self-assessment of their competence to work with clients with disabilities as well as the indicators they take into account to evaluate their level of competence. These questions were also aimed to capture the changes in the progression or process of development of disability competence, if this was the case for the participants. These questions included, "How would you describe your current level of competence working with clients with disabilities?" and "If this is the case, how has your competence working with clients with disabilities evolved over time?"

Follow-up prompts to these initial questions included, "How does this competence to work with clients with disabilities look like in general? how does it look specifically for you?" "How is this competence situated in terms of awareness, knowledge, and skills?" "What are the indicators you take into account when defining your level of disability competence?" and "What has facilitated/hindered this evolving process?" Within this area of exploration, some questions attended to contextual and cultural aspects of the counseling work with clients with disabilities. Furthermore, in alignment with Corbin and Strauss' (2015) feminist emphasis for contextualized descriptions, other questions included, "How is your competence working with clients with disabilities influenced by the interaction of other cultural identities?" and "What cultural dimensions (in the client and the counselor) impact and complexify the work with these clients?"

Finally, given the seemingly present incongruences between multicultural competence and disability competence in counselor training (Olkin & Pledger, 2003; Pieterse et al., 2009; Smart & Smart, 2006), the last area of exploration within the interview included questions aimed to contrast and compare the competence to work with diverse groups. Specifically, the interview questions included, "How do you compare the competence working with clients with disabilities with multicultural competence?" What are the similarities between these two?" and "What are

the differences between these two?" Refer to Appendix F for a list of the questions for the first interview.

Following the first round of interviews, I completed a first round of coding, then I conducted the first member check or interpretive dialogue interview with each participant in order to expand interpretations in a collaborative way and refine the descriptions. After completing the first interpretive dialogue, the data was refined and adjusted depending on the fitness to the interpretations, confirmation, or disconfirmation of the participants. Throughout this process, I kept memos and reflexive journals that were later used to triangulate the data and refine the findings.

Also, from this first round, additional questions were defined for the second round of interviews. As the first round of interviews and interpretive dialogue interviews were completed, I proceeded to conduct the second round of interviews and subsequent member check or interpretive dialogue interviews. At this point, I started the process of theoretical integration where constructs and descriptions started blending and composing a more structured theory of the phenomenon of study. The final interpretive dialogue was enhanced by the participants' review of the emergent grounded theory of the development of disability competence in licensed professional counselors. See Figure 1 for a diagram of the sequential steps involved in the research process.
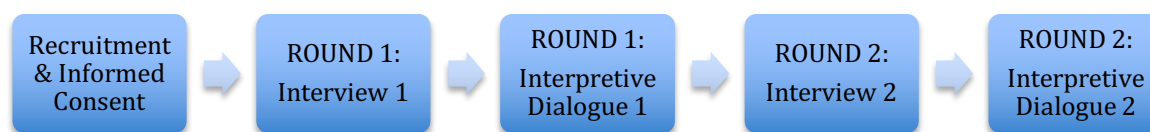
Figure 1. Sequential steps involved in the research process.

Data Analysis

According to Corbin and Strauss (2015), the data analysis of grounded theory is "more than going through a document and denoting concepts at the end of each line to stand for data" (p. 64) and entails a variety of mental activities conducive to the interpretive process in the search of theoretical meaning, which starts from the initiation of data collection. Furthermore, Corbin and Strauss (2015) emphasized the need for microanalysis as the "form of coding that is open, detailed, explanatory [and is] designed to focus on certain pieces of data and to explore their meaning in greater depth" (p. 70) during the initial stages of data collection and analysis. I started my analysis by focusing on the generation of possibilities and contrasting them against the data in order to arrive at the most meaningful codes in the theory construction.

The process of data analysis and theory construction is intended to articulate the words or actions of the participants in relationship to the phenomenon in an organized manner. As these concepts are organized, the level of abstraction evolves from lower-level concepts to categories, and further, to core categories (Corbin & Strauss, 2015; Creswell, 2013; Hays & Singh, 2012). Open coding was defined by Corbin and Strauss (2015) as the search for major categories and the identification of potential keywords. As I started open coding the data, I worked to distinguish the general domains that I was identifying from my participants' experiences through the use of keywords or phrases. I also worked on identifying the emerging constructs and categories in the form of broad and specific codes (Hays & Singh, 2012).

Once I defined these open codes, I proceeded with axial coding of the data where I aimed to establish preliminary relationships between the open codes and worked to arrive to a more in-depth understanding of the participants' descriptions in order to facilitate theory construction (Corbin & Strauss, 2015; Creswell, 2013; Hays & Singh, 2012). At this point, I started

organizing, dividing, and collapsing initial open codes to start identifying the emerging

relationships between the open codes. I engaged in a dynamic process with the data, remained

open, and allowed myself to remain curious in the identification and re-organization of these

emerging relationships as the process of analysis and data collection evolved; however, I was

intentional in the attempt to identify potential causal conditions, intervening conditions, and

consequences in the multiple dimensions of my emerging core codes (Creswell, 2013; Hays &

Singh, 2012). Further, I worked to integrate these emerging codes into a logical sequence and

visual model that represented a theory or an explanation for the development of disability

competence in licensed professional counselors (Hays & Singh, 2012).

Next, I used selective coding to refine the axial coding and these preliminary

relationships identified (Corbin & Strauss, 2015; Creswell, 2013; Hays & Singh, 2012).

According to Hays and Singh (2012), "selective coding is the most complex coding process in

grounded theory, whereby patterns, processes, and sequences are identified among axial codes to

generate a theory about the phenomenon" (p. 345). Even though some of these relationships were

preliminary identified before, through selective coding these relationships and codes became

established and integrated in a logical sequence that represented a theory or an explanation for

the development of disability competence in licensed professional counselors. In this last

process, Corbin and Strauss (2015) emphasized the need to identify a central category, which

appears frequently and naturally emerges in all data. This central category was named in a way

that could be researched in other studies, and also evolved in its power to explain the

phenomenon studied (Corbin & Strauss, 2015; Hays & Singh, 2012). Finally, this interpretive

process of participants' experiences ended with the integration of codes towards the construction

of data that was represented through a visual model about the theory that explains the phenomenon.

This structured process occurred in different analytical or coding steps: open, axial, and selective. In each of these coding steps I engaged in scholarly curiosity and remained flexible to gravitate towards different directions in the process before committing to specific categories or themes. This curiosity and flexibility was manifested by my ability to re-think, expand, merge, go back, and consider negative cases throughout my interpretative process. I also used the interpretive dialogue interviews to add further complexity to the descriptions as well as to the directions taken within my emerging analysis.

The coding and analytical process was completed during the first round of interviews through constant comparison and afforded the refinement of questions and descriptions for the second round of interviews. The emerging analysis was presented to participants in each interpretive dialogue interviews as a form of engaged member checking. Analytical decisions were made at the end of round one and two in order to generate, identify, and describe a theoretical explanation of the phenomenon that is fundamentally grounded in the participants' descriptions.

Trustworthiness

Integrity and trustworthiness in the research design, data analysis, and documentation of the results are determining factors when judging the quality of qualitative research (Hays & Singh, 2012). Specifically in grounded theory, Corbin and Strauss (2015) emphasized the enhanced research rigor resulting from methodological consistency, clarity of purpose, self-awareness, and creativity. According to Hays and Singh (2012), there are specific criteria for trustworthiness as well as strategies to be implemented. Specifically, Hays and Singh (2012)

mentioned the trustworthiness criteria of credibility, transferability, dependability, and comfirmability. As a researcher, I strived for integrating strategies that enhanced the trustworthiness of my qualitative design and research process.

Credibility in qualitative research was defined by Lincoln and Guba (1985) as the "naturalist's equivalent for the conventional terms 'internal validity,' 'external validity,' and 'reliability" (p. 300) of a study. Qualitative researchers strive for credibility as it is considered criteria to determine if the conclusions and findings of the study make sense (Hays & Singh, 2012). In this study, some of the strategies for credibility included integrating diverse forms of documentation for enhanced record keeping, triangulation, and peer debriefing.

In terms of documentation, my study was well documented as accurate descriptions from the participants were deepened throughout data collection and transcribed in an accurate manner. Moreover, as a native Spanish speaker, I worked to clarify words that had different translations, based on my enhanced understanding of many cultural meanings and signifiers present in my participants. Throughout the collection of data, I also documented memos and diagrams that enhanced my possibilities to interact with the data "examining it, making comparisons, asking questions, coming up with concepts to stand for meaning, and suggesting possible relationships between concepts" (Corbin & Strauss, p. 107). The use of dated memos and diagrams helped me document the sequential mental process that was later integrated in the analysis. The record keeping of these mental processes was extended to the use of reflexive journals, which allowed me to document "how the research process is impacting the researcher" (Hays & Singh, 2012, p. 205) as I immersed myself in the data and the reciprocal data analysis (Corbin & Strauss, 2015). I was intentional in documenting my theoretical linkages, emerging code relationships, and personal reactions to the intersectional variables and effects that emerged in my participants'

descriptions of their development of disability competence. I worked to remain mindful of the dimensions at play and make sure I documented them.

Triangulation in qualitative research involves utilizing diverse forms of evidence to support and better describe findings (Hays & Singh, 2012) and to increase the credibility of the results (Lincoln & Guba, 1985). For increased trustworthiness, I triangulated data sources by "including several perspectives or participant voices during qualitative inquiry" (Hays & Singh, 2012, p. 207). In other words, I worked to collect and confirm data from different sources and opportunities in order to decrease the limitations from using a singular source. In this sense, I conducted data collection in the two rounds of interviews and also had member confirmation interviews during the process or interpretive dialogues, in order to enhance participant's engagement in confirmation and refinement of the codes and emerging analysis.

I also triangulated the sources by integrating the perspective of an auditor who determined "the extent to which the researcher completed a comprehensive and rigorous study" (Hays & Singh, 2012, p. 209). A licensed professional counselor unrelated to the data collection served in the capacity of an external auditor as a final step in the analysis process. The professional counselor recruited to serve as an auditor in this study had lived for twenty years with a physical disability. The rationale for selecting this auditor related to my intention to honor the insider view of the participants while having a licensed counselor with a disability who is unrelated to all other aspects of the research process. This licensed counselor was recruited towards the end of the data collection process, through the same strategy as the rest of the participants. In terms of theoretical triangulation (Hays & Singh, 2012), I grounded my understanding of the participants' descriptions on the existing literature on the research gap. In this way, the participant's experiences were consistently triangulated with their follow-up

descriptions as well as with the existing literature about the development of disability competence for licensed professional counselors.

I engaged in peer debriefing as a final strategy for credibility of my qualitative conclusions. Peer debriefing "allows for another check […] that serves as another vehicle to challenge the findings" (Hays & Singh, 2012, p. 211) and "test working hypotheses that may be emerging in the inquirer's mind" (Lincoln & Guba, 1985, p. 308). I planned on having continuous peer debriefing sessions through the work with my dissertation chair and advisor Dr. Nicole R. Hill in order to corroborate the emerging codes and theory. Therefore, through documentation, triangulation, and peer debriefing, I strived for a contextualized and dependable description of my participants' experiences related to their development of disability competence as licensed professional counselors.

Another strategy for trustworthiness is transferability. According to Lincoln and Guba (1985), transferability is equivalent to external validity in the quantitative research sense. Hays and Singh (2012) emphasized qualitative research's goal for thick descriptions of the research process "so that readers can make decisions about the degree to which any findings are applicable to individuals or settings in which they work" (p. 200). Transferability in this study was addressed through the use of thick descriptions and rich narratives of the participants' contextualized experiences. This kind of descriptions facilitated the reader's deeper understanding of the constructs described during the results section and assisted the reader in deciding if these descriptions were adjusted to their particular context (Hays & Singh, 2012; Lincoln & Guba, 1985).

Dependability is another strategy for increasing trustworthiness in qualitative research and "refers to the consistency of study results over time and across researchers" (Hays & Singh,

2012, p. 201; Lincoln & Guba, 1985). For this to occur, the emerging and final findings need to be agreed upon by the participants, research team, and the external auditor. I strived for dependability by co-constructing an interpretive consensus in the interviews, interpretive dialogue interviews, and peer debriefing sessions.

Confirmability relates to the degree to which findings of the study are genuine and accurate reflections of the participants' experiences (Hays & Singh, 2012). One way to increase comfirmability includes the use of member checks where data, analytical categories, and emerging conclusions are reviewed by the participants. This is considered "the most crucial technique" for confirmation of results (Lincoln & Guba, 1985). I integrated comfirmability strategies through the use of member checks in the form of interpretive dialogues and auditor review. These member checks in the form of interpretive dialogues provided opportunities to assess intentionality in the narrated descriptions, correct errors in the representation of experiences, and test the adequacy of the participants' descriptions (Lincoln & Guba, 1985). Moreover, member checking in the form of interpretive dialogue interviews increased comfirmability of the findings by asking the participants "how well the ongoing data analysis represents their experience" (Hays & Singh, 2012, p. 206).

I intended to conduct a research study that was qualitative in nature and which sought to portray a close description of my participant's experiences and realities in relation to the phenomenon. My study's trustworthiness was enhanced by my ability to integrate strategies for credibility, transferability, dependability, and comfirmability. I strived to remain as truthful as I could of my reflexivity as a researcher with the intention of producing an emerging theory fundamentally grounded on the participant's descriptions and facilitated by my positionality as a researcher of color.

Conclusion

The development of disability competence in the professional practice of licensed counselors is a process that is influenced by a variety of factors and that determines the possibilities for engagement and treatment of the largest minority in the United States. In order to understand this complexity of factors, I chose qualitative research, specifically the grounded theory tradition. Grounded theory allowed the construction of the theory about the phenomenon as the participants experience it. I remained reflexive of the aspects that informed my understanding of the data, my relationship with the participants, and the overall analysis. The purpose of this study was to illuminate the complexities of the underlying processes, properties, and dimensions involved in the development of disability competence of licensed professional counselors. The following chapter will describe the participants' responses to the first round of questions.

Chapter IV: First Round Analysis

Introduction

The collection of data for the first round of interviews took place at the end of the Fall 2016 semester. The twenty-one participants were carefully and purposefully selected by confirming licensure information and participation criteria in publicly available repositories of each state. Prior to the engagement in the first interview, the researcher went over the signed consent form and a brief demographic questionnaire to clarify potential questions about the study, confirm willingness to participate, and remind the participants about their right to discontinue participation at any point of the interview. Round one interviews started during the first week of December 2016 and the subsequent data analysis was completed by the second week of January 2017.

Strategies to Increase Trustworthiness

As I moved throughout the interview process, I experienced increased points of connection with my participants' stories. These connections were mostly grounded in my identity as a professional counselor and a graduate from a CACREP-accredited program, who is in the process of obtaining licensure in the state of New York, and who works in an outpatient clinic serving clients with disabilities in English and Spanish. I became increasingly aware that I actively used these experiences as a framework to understand my participants' narratives. However, this increased awareness kept me grounded in my commitment to afford the space for participants to freely describe their stories and take part in the co-construction of the emerging interpretation of their journey. Moreover, this collaborative process allowed me to capture and honor the different dimensions of identity that my participants embodied and that directly influenced their experience of the phenomenon.

My ability to reflect and document this internal process evinces my commitment for trustworthy research and for the most integral representation of my participants' stories. For this purpose, during the first round of interviews and analysis, I enacted all the strategies for trustworthiness described in Chapter III. These strategies entailed: record keeping, triangulation, and peer debriefing to guarantee the credibility of the results; the use of thick descriptions and rich narratives of the participants' contextualized experiences to guarantee transferability; the co-construction and interpretive consensus in the interviews, interpretive dialogues, and peer debriefing sessions to guarantee dependability; and the use of answer checking throughout the interview in order to guarantee comfirmability.

In order to increase credibility and trustworthiness, all interviews were audio recorded and transcribed by a specialized service to assure the reliable description of participants' experiences. Furthermore, as I conducted, read, open and axial coded, and analyzed each interview, I documented my thoughts and reactions emerging from my interactions with the data. These journals and analytic memos became an analytic space to establish connections, linkages, and delimitations between the emerging codes. This ongoing process became instrumental to further delineate the themes, properties, and dimensions in my analysis. Specifically, two of my emergent themes, Evolving Compromises and Systemic Dimensions, materialized through my continuous use of analytic memos as I identified the factors embedded in developing competence and the overall systemic forces that impact this process.

As a form of triangulation, I grounded my understanding of the participants' descriptions in the existing literature. In this way, the participants' experiences were analyzed in relation to existing literature about the development of disability competence for licensed professional counselors. In terms of peer-debriefing, I collaborated with my dissertation chair and advisor, Dr.

Nicole R. Hill, in the identification and clarification of the emergent analysis. Sharing the emerging analysis with Dr. Hill helped me confirm and substantiate my preliminary impressions of the data provided by the participants. Moreover, as I transitioned to axial coding and initiated the use of Figures and diagrams to depict these emerging themes and their interrelationships in my analytic memos, I was able to further strengthen and consolidate the preliminary themes and subthemes identified. I felt stimulated and encouraged when arriving at the initial understandings of the data that were grounded in the existing literature and that resonated with the emergent impressions of my advisor.

In order to facilitate readers' transferability as a strategy for trustworthiness, I used the transcribed narratives that depicted participants' thick descriptions of their interactions with disability competence. I was able to achieve this by organizing my preliminary analysis in a document that has extended and meaningful participants' excerpts embedded throughout. I also engaged in constant comparison between the interactions with the participants and the evolving analysis (Corbin &Strauss, 2015) as I embarked in the initial identification of categories and their corresponding dimensions and properties during the first round of interviews. Specifically, I went out to the field to gather information from the participants through interviews, then immersed into my analysis of the data, then back to the participants to collect more information, back to the analysis of the data, and so forth.

Additionally, dependability as a criterion for trustworthiness was achieved by intentionally affording the space for the co-construction of meanings through the interactions with the participants. For instance, I engaged the participants in interviews by presenting open questions and prompting the participants to elaborate on their descriptions based on their experiences. Also, in my peer-debriefing interactions with Dr. Hill, I worked to clarify

understandings and achieve consensus of the emerging findings. Finally, in my attempt to generate findings that are genuine and accurate reflections of the participants' experiences as a measure of comfirmability, I continuously checked for shared understanding and confirmed assertions and descriptions with my participants throughout each interview. Engaging the participants in a member check or interpretive dialogue in the following weeks further ensured comfirmability.

Description of the Participants

Twenty-one licensed professional counselors engaged in the first round of interviews. From this sample, seventeen of the participants self-identified as female, three as male, and one as gender queer. With an age range from 27 to 59 years of age ($M = 36.9$, $Sd = 7.6$), nine of the participants worked in outpatient clinics, six participants worked in private practice, five participants practiced in schools or higher education institutions, and one participant worked in a day program for clients with disabilities. Nineteen counselors self-identified as White/Caucasian and two self-identified as Latina. Also, seventeen participants self-identified as heterosexual, one as pansexual, one as gay, one as open, and one person declined to answer this question. Eight of the participants self-identified as having a disability that varied from chronic illness, ADHD, to mobility impairments. All the participants spoke English as their first language, and three spoke Spanish as their second language. The three participants who spoke Spanish offered counseling services in Spanish.

Participants' year of graduation from CACREP-accredited programs ranged from 1996 and 2014 and the years of licensed practiced ranged from 1 to 10 years ($M = 4.7$, $Sd = 3.5$). All participants served clients with disabilities and the range of disabilities they served included physical, developmental, cognitive, and sensory disabilities, ensuring variation of disability

representation. The number of clients with disabilities served by the participants currently ranged from 1 to 112 clients. From the total sample, six participants (28.6%) acknowledged not attending any trainings related to disability after graduation. Eight participants (38.1%) attended between one and three trainings, and six participants (28.6%) attended more than 10 trainings related to disability after graduation. Two participants (9.5%) recalled taking disability-focused coursework during graduate training. In order to ensure confidentiality, the participants were requested to generate a pseudonym to be used in the write up of the findings. See Appendix E for a chart with the corresponding names and the description of the participants' characteristics.

First Round of Interviews and Emerging Analysis

To analyze the first round of interviews I read and coded of each participant's transcript. My analysis of these transcripts involved both open and axial coding of the participants' raw descriptions of their interactions with disability competence (Corbin & Strauss, 2015; Hays & Singh, 2012). In the open coding process, some themes were identified and were further classified and organized into sub-themes or categories through the axial coding process. Moreover, as these themes and sub-themes were organized, some relationships between them were preliminary established. During the first round of interviews, five emergent themes were preliminarily identified: **The Therapeutic Work**; "**It Takes a Village"**; **Evolving Compromises**; **Competence**; and, **Systemic Dimensions**. Following is a detailed description of these themes or categories and their sub-categories with participant narratives to substantiate the emergent findings.

The Therapeutic Work

The Therapeutic Work with clients with disabilities was defined by most of the participants as "intriguing" and "rewarding," and as an emerging area of development in their

role as LPCs. Within this theme, participants described confusion around the definition of disability as mental health counselors. Participants also highlighted the importance of the counseling relationship as well as individualized approaches in the work with clients with disabilities. Within this theme, three subthemes were preliminary identified: ***Disability as identity***; ***counseling relationship***; and, ***tailoring the approach***. Figure 2 presents a description of the sub-categories of **The Therapeutic Work**.
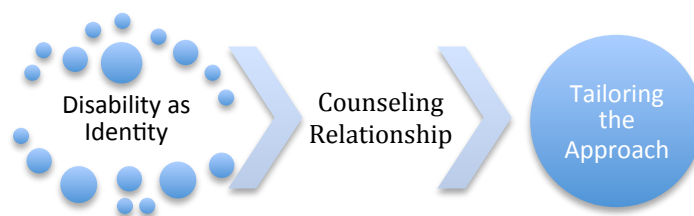
Figure 2. The Therapeutic Work

Disability as identity. Most of the participants expressed confusion about the classifications of disability and framed it as an identity that directly refers to medical conditions that impact the daily functioning of clients. For most of the participants, disability has elusive boundaries so to include pervasive mental illness, chronic illness, and substance abuse. Many participants situated ***disability as an identity*** that goes beyond the medical definitions of functioning to include persistent mental illness and substance abuse. In general, participants have encountered clients with physical (i.e., wheelchair users, persons missing limbs, persons with health conditions such as cancer, brain tumors, lupus, traumatic brain injuries), intellectual or cognitive (i.e., intellectual disability, learning disabilities), developmental (i.e., Autism, cerebral palsy, spina bifida), and sensory disabilities (i.e., deaf, blind) in their professional practice. Tela utilized a dimension of governmental benefits to substantiate her determination of who is considered disabled, but then began to question this definition.

TELA- Then [I thought] 'Well who do I see that's technically considered a person with disabilities and who is granted disability insurance and all that […] so it really started to challenge my thinking about who is considered disabled.

Additionally, participants identified the ability to walk, learn, see, and hear as a spectrum that overlaps with mental health distress depending on the client's life circumstances. Allison's excerpt showcases the overlap between mental health symptoms and disability, but also how she views disability as somewhat distinct from mental health.

ALLISON- I do have experience working with individuals who claim they have a psychological disability. Or their substance use has impacted them to the point where they cannot function in society. But again, I think of disability as developmental disability. I really do, I really do. I really do think of it as cognitive disability and physical disability. I don't think it is the mental health, for which is challenging because it is, but it isn't at the same time. I don't know.

As the participants started thinking about their client's disabilities as an identity influencing the counseling work, participants unanimously emphasized the counseling relationship as a foundational aspect of the work with clients with disabilities.

Counseling relationships. Participants unanimously insisted on the importance of the *counseling relationship* and the need for client-centered engagement when working with disabled clients. According to the participants' descriptions, a genuine, non-judgmental approach, and unconditional positive regard greatly fostered the counseling relationship. Gloria highlighted the importance of a non-judgmental stance when working with her disabled clients, whereas Otilia, Natalie, and Kara further situated the counseling relationship as a central component in the work with these clients.

GLORIA- I think the fact that I don't judge it, and I just accept it as just another element of their lives has been helpful, and I think they respond to that in terms of the relationship.

OTILIA- Developing relationships with kids, working with families. I've had people say, 'He's been to other providers at [other agencies] and you work really well with my son.' Or, 'They really enjoy seeing you.

NATALIE- Therapeutic relationship. Every single bit of theory about how the therapeutic relationship is the most important and all the research is completely true […] It was like therapeutic relationship and then that grew into, the second piece I think was meeting the patient really where they're at.

KARA- Definitely, the relationship. I think the relationship is probably the most important. Then again, too, not just always going to back to the same types of interventions, really trying to make the interventions work for the client, and being person-centered. I don't know, it all sounds so textbook, but I feel like it's also true.

The emphasis in the counseling relationship was manifested differently by the participants. For instance, some participants stressed the importance of genuine and compassionate care and of meeting the client where they are. Jerome and Reece described this in the following ways:

JEROME- I think you could learn all those skills about disability, but be really in-genuine, and that won't help you. I don't think you can do it without having some sense of genuine care for people. I firmly believe that.

REECE- Say I'm pretty knowledgeable in working with individuals with different disabilities, especially when it prevents them from doing certain things because again, I'll

just try to meet them where they're at, see what is the disability, what is it preventing

them from doing, link them to resources.

Furthermore, participants highlighted the importance of connecting with the client through the

counseling relationship for them to feel listened to and empowered. Peter and Kara emphasized

the importance of the ability to connect with the client as professional counselors, and Sarah

linked this connection to the power of listening.

PETER- [What helps me do this work is] my ability to connect, I have a very strong

ability to connect with the population.

KARA- I think having that rapport and connectedness to clients, I don't think that you

could really be effective at all if you don't have that.

SARAH- I've learned to never underestimate the power of listening […] I would say that

clients would feel listened to and they would feel empowered and they would feel

respected. And they would feel that I'm doing the best job, and to me that's - I'm doing

the best I can."

Thus, the participants situated the counseling relationship as the space to capture and strive for

meaningful individualized interventions that required professional counselors to tailor the

approach when working with clients with disabilities.

Tailor the approach. Once the counselor has gained an understanding about the client's

disability through the engagement in the counseling relationship, participants insisted that

meeting the client where they are at requires them to ***tailor the approach*** by clarifying

information, checking in continuously, adjusting language, and integrating accommodations

based on the client's disability and needs. Sarah emphasized the need to take the time to adjust to

the client's verbal abilities, Jerome and DDD stressed the need to remain mindful of the use of

language in the sessions, and Unice highlighted the importance of finding materials and activities that meet the client's specific needs.

SARAH- It takes a minute to get comfortable working with someone who has had a stroke and slurs their words and you have a really hard time understanding or things like that.

JEROME- It's just making sure that you stay mindful that there's an extra step. I would say that's pretty common with the folks I work with autism too, is being mindful that the language you use, they may not understand it, or they may not get a social cue, or they may not get a body language, so being mindful of folk's disability in the sense that the role that it plays in the greater sense of how you're counseling them.

DDD- It becomes really important for me to be mindful of my language and communication skills, I have come to learn that in a really fast paced world, a lot of us, including myself work on assumptions that people understand or have the same set of information that I have. Also, jump to think that even that they have this information that they understand and can integrate the information.

UNICE- I try to get things from the internet that are already translated. You know there is a lot of information on the internet, but again, the way it is displayed in a way that my client might not take advantage of, so I will take it from the internet but again I have to modify it so I'll draw pictures, if they are able, I'll do physical activities that kind of send the message you know, using examples form their every day life. I will try to help them gain the understanding that I am looking for in a way that they can relate to.

Furthermore, some participants highlighted the importance of remaining flexible and being creative when planning the approach to working with clients with disabilities. For some

participants, flexibility included the active and intentional use of expressive techniques such as art-related and narrative interventions to facilitate the symbolization process in the therapeutic work. DDD stressed the need for flexibility when designing interventions, whereas Lynn and Natalie exemplified this flexibility through the use of expressive arts and narrative techniques in their work with clients with disabilities.

> DDD- I think, to be able to have that flexibility and to know your intent and purpose when it's really changing still quickly when you move to those different levels of intervening task.

> LYNN- Also the expressive arts community was really helpful, art therapy. Learning from my master's degree is in education, and as part of that degree, I had taken several courses on working with students with disabilities. That training and learning about the adaptive and assistive technologies, that never would have been part of my counselor training, but that was very helpful because I knew that there were resources and adaptations out there. […] I think that one of the things that I learned from my experience at the Rape Crisis Center, not just from working with clients with disabilities but just working with trauma in general, is that something that I just started doing is offering art from the very first session, so just having crayons and papers.

> NATALIE- We sort of would analyze what she was going through and in a little different of a way than I would with "normal" folks that can speak to their social interactions much more easily, that obviously didn't have a disability in that area. We used creative things that she was doing. She would do these writings and these drawings of this character that was this guinea pig named Cosmo and she would have a fantasy world. […] Very quickly I just grew this affinity for her, just this fondness and I was just like, I just felt like I'm

going to do the work to understand where she's at in her mind and that's why when we

started working with ... So like okay, how can I sort of like sort of understand what's

going on in her mind. Once she said that she wrote and drew these characters I was like,

lets talk about that. Bring in what you write. I started getting this sense of her inner world

through her imagination and her creative experience and I was able to meet her.

The subtheme tailor the approach encompassed the most common ways in which participants described the work with clients with disabilities within the counseling sessions.

In summary, and it is evident in Figure 2, the participants described the process of realizing the nature of the work with clients with disabilities by understanding the disabling condition, fostering and cultivating the counseling relationship, and tailoring the approach according to the goals and the needs of the client. Furthermore, while commenting on this process, the participants mentioned the resources used in doing this work. The next theme "It takes a village" describes the multiple components and resources involved in this work for the participants.

"It Takes a Village"

All participants recognized that counseling work cannot be done in isolation. The participants highlighted the importance of using community resources and interchanging with the extended network of providers to increase the effectiveness of the counseling work. Participants often made reference to the phrase "It takes a village" to indicate the collective and collaborative nature of their approach to the work with clients with disabilities. This phrase was popularized by Hillary Clinton in 1996 in her book that presented her vision for the children of America, and the impact of the community on children's well-being.

Within this "village," the participants highlighted the importance of learning and nurturing the counseling work through the interactions with supervisors, institutional and self-initiated learning opportunities, and their interactions with their clients' extended communities. Therefore, within this theme, three subthemes were preliminary recognized: ***Collaborative relationships***, ***learning communities***, and ***clients and families narratives***. Moreover, two resulting dimensions were identified: ***Circle of trust***, and ***expertise***. Participants described this process as continual and persistently ongoing. Figure 3 presents a description of the sub-themes of **"It Takes a Village."**

Figure 3. "It Takes a Village"

Collaborative relationships. Participants unanimously expressed the importance of interactions with supervisor, peers, and other professionals (i.e., social workers, case workers, Medicaid Service Coordinators, and psychiatrists) through ***collaborative relationships***. In terms of supervision, Eliza and Iris highlighted the importance of responsive clinical supervision that not only addresses the needs of the clients but also the development of the counselor, whereas Cortina participant emphasized the need for specialized supervision that would include a supervisor with disability experience and rehabilitation training credentials.

ELIZA- Supervision. Supervision 100 percent. Supervision with my supervisor, consultation with many different staff, other supervisors, clinicians. Again, collaboration with psychiatry.

IRIS- Also having appropriate supervision. Having a supervisor that understands that you can't take a client who has a disability and expect them to make the same gains as someone who has a fully functioning body and fully functioning brain. Someone who, I don't want you to think that people with disabilities can't make the same steps. They can make the same steps, but the steps have to be tailored towards them. Having a supervisor that understands. Having a supervisor that is able to look at your work and say, 'It makes sense that it's gonna take this patient longer and this client longer to work on their stuff.' That has been really important. Having the supervision.

CORTINA- [Higher competence] would come from having supervision of someone who specializes in working with clients with disabilities.

An aspect of the collaboration with others in the professional environment includes other mental health professionals that are in professional relationship with the specific client or who serve the same population, and therefore, represent a source of information and consultation. Henry's description illustrates the collaborative nature of the counseling work that extends beyond the boundaries of the counseling room and reaches adjunct services, social workers, and case managers who are in connection with the client.

HENRY- Being linked with adjunct services. If I had a patient that had a traumatic brain injury, being linked with their social worker or other patients that had certain disabilities. Being linked with their social worker who also has an established rapport with them and touching base with them about what works to connect with the client […] I mean more

like a case manager. Using adjunct services to help me fast-track a connection with the

client, that's helped. Also having other, just being in connection with other services to the

client has often helped me, given me the ability to adjust my techniques to meet the

client's needs.

Also, other participants expressed the importance of having peer consultation and building a

support network with peers in the work environment to debrief after sessions and learn from each

other. Brittney and Unice described the importance of having professional peer communities that

represent consultation and support.

BRITTNEY- I found that having a really supportive group of co-workers that I became

friends with was really helpful. You know, it was kind of like an outlet of people who

knew exactly how you felt at the end of the week, that have the same struggles going on.

And it was just really easy to let go and, like, kind of do supervision amongst ourselves, I

guess you could say, because when I was working in [name of the program], it was...

supervisors weren't readily available and they had their own work to do, so supervision

among peers was always kind of the best way bounce ideas off of each other and deal

with difficult clients.

UNICE- I try to stay abreast of everything that exists. I'm very in touch with my

community. I'm still in touch with some of the agencies and non-profit agencies that exist

in the community. I have my contacts. I bounce a lot of things back and forth with my

other colleagues sometimes if I'm not a hundred percent sure, or I reach a level where I

feel like I'm at a standstill. We brainstorm.

As participants described the importance for collaborative relationships that represented support

and consultation through peer debriefing and supervision, they also mentioned the learning

opportunities that are available to them through different sources in this village. These descriptions have been organized within the sub-theme of learning communities.

Learning communities. Participants also mentioned the importance of immersing themselves in *learning communities* to amplify knowledge and get in contact with professional communities that work with similar counseling issues. Participants commented on their access to knowledge and learning through their institutions of employment, professional organizations, and publicly available information (i.e., internet). Queen described her appreciation for continuous training required by their licensing boards, specifically in the form of continuing education units (CEU), and highlighted the need for trainings focused on disability issues. Moreover, Henry and Natalie emphasized the benefits of partaking in learning opportunities afforded through their affiliation to professional organizations (i.e., professional conferences).

QUEEN- I also think just having a path, continuing the education path would be helpful. I'm very appreciative that our licensure now is going to call for those 30 CEUs over a two year period. I think it's fantastic […] but I really would like that to include different dimensions. One of the dimensions being continuing education in understanding disability, understanding some of the legal aspects, understanding some of the experiential aspects, but probably more so some of that.

HENRY- I'll definitely say that what has helped me if the ongoing training. I was at the American Mental Health Counseling Association their conference last summer. They have some trainings about working with individuals with disabilities. Those helped.

NATALIE- I go to conferences, I'm like the conference slut. I literally go to every training and every conference that's free up there. If it's not free I'm still trying to get

there. I've been looking for something that would answer my questions about autism in the area or even webinar and I haven't come across anything.

Through the engagement in their learning communities, all participants emphasized the value of continuous education in the work with clients with disabilities. Even though participants described formal trainings in the form of workshops and seminars available to them, their descriptions of the village also represented learning opportunities through their engagement with clients and their families' narratives. According to participants' descriptions, furthering their connection and engagement with the clients and their extended communities, would afford additional opportunities for obtaining knowledge of their social realities.

Clients and families narratives. Lastly, participants mentioned the importance of learning from the ***clients and families narratives*** in the attempt to tailor the best approach possible depending on the client's life circumstances and counseling needs. DDD highlighted the value of the collaboration with clients in order to understand their perceptions and needs. Moreover, Henry emphasized the need to step away from the expert role when working with clients with disabilities.

DDD- I'm good at collaborating with my clients. I think their perceptions and what they need is just as important

HENRY- I think what's actually helped me to get as competent as I am is I've actually learned from a lot of clients that have understood that the therapist doesn't know what it's like to be them. I think kind of taking that approach, reiterating to the client that I'm not the expert on them, that's helped me to learn from my clients. I've been actually really lucky to have clients that actually train me.

The participants' ability to connect with and learn from the clients and their extended communities represented additional domains of engagement as professional counselors. Specifically, the engagement with clients and families narratives further fostered opportunities for the participants' realization of the issues impacting the family system, as well as their collaboration with other mental health professionals.

Process dynamics for "It takes a village". While describing the components of the "village" needed to do the counseling work with this population, some participants commented on the continuous nature of the immersion in this professional, learning, and personal network. As it is evident in Figure 3, the sub-themes collaborative relationships, learning communities, and clients and families narratives organized the professional community experiences of licensed professional counselors working with clients with disabilities. The juxtaposition of these sub-themes not only accounted for their occurrence in intertwined and seemingly productive ways for counselors, but it also created cyclical patterns of collaboration and learning that were described as ongoing by the participants.

As a result, participants stressed the resulting formation of tight networks of support, or *circle of trust*, as licensed professional counselors and the eventual development of a perceived proficiency, *expertise*, in issues consulted and populations served. Sarah described her identification of professionals to go to when having questions, whereas Maria expressed the need to engage in continuous education to develop proficiency in specific issues impacting her clients with disabilities.

SARAH- I would have to say, by far, peer consultation and clinical supervision has been the best. Although, getting an understanding from a psychiatrist point of view on how certain disabilities will impact - and I, in particular, have my people to go to when I need

to […] so I have clinical social workers to LPCs to psychologists, and even psychiatrists within my circle of trust.

MARIA- Because I think there's always more to learn. There's new information all the time, and there's new disorders that are coming out. I'm not an expert, and I never will be. I think I maybe have more expertise than somebody else could, but I never think I'm certainly going to know everything.

From the participants' descriptions, it is noticeable that aspects of self-initiative and development directly impact the counselor's ability to engage in professional and learning communities. These personal and professional dimensions are identified in the next theme, counselors' Evolving Compromises.

Evolving Compromises

The majority of participants mentioned the evolving compromises to their role as LPCs as well as to the population of clients with disabilities. These evolving compromises explained the participants' navigation of initial negative reactions when encountering disabled clients, their self-initiated learning around disability issues, as well as their achievement of sense of professional and personal purpose. Within this theme, three sub-themes were identified: *Negative attitudes*; *self-initiation*; and, *sense of purpose*. Also, three process variables were recognized: *Reflexivity*; *time and development*; and, *experience and exposure* to clients with disabilities. Participants considered the latter process variable as the necessary environment for these compromises to evolve through professional practice. Figure 4 illustrates the sub-themes of **Evolving Compromises** by juxtaposing reflexivity and time/development as the catalysts for the overcoming negative attitudes, the transition to self-initiation, and the achievement of sense of purpose through experience and exposure to clients with disabilities.
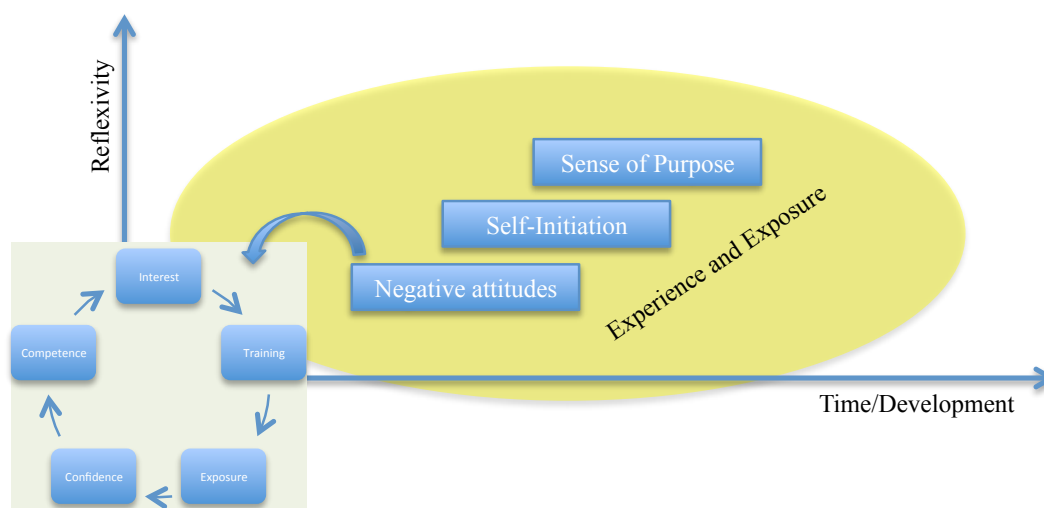
Figure 4. Evolving Compromises

Negative attitudes. Many participants commented on their initial experiences of avoidance and biases that informed ***negative attitudes*** related to the counseling work with clients with disabilities. From not being interested in the work with clients with disabilities, participants did not engage or did not actively seek out opportunities for training or exposure to these clients, which then decreased their level of confidence and their overall competence to work with clients with disabilities. ***Negative attitudes*** were also explained by the participants in terms of biases and the immediate reactions experienced in the work with clients with disabilities. Natalie, Cortina, and Faith provided descriptions of their negative reactions and biases associated to the work with clients with disabilities. Natalie and Cortina described initial avoidance to clients with Autism, prominent doubts about the ability to connect with these clients, as well as reactions of sadness and pity for her disabled clients. Moreover, Faith expressed biases related to the clients needing to have certain level of ability in order to engage in therapeutic work.

NATALIE- I remember when [the client] came in, my first thought was, ugh, I do not

want to work with a person with a disability, especially Autism. That was something that

not only did I not feel prepared, I actually didn't want to deal with it. I have zero social

issues. I also have zero learning disabilities and zero intellectual deficits. I am literally

really, really smart. I was like, I'm never going to be able to connect with these people so

I don't ever want to work with them. It sounds horrible but I felt that I couldn't connect, I

couldn't understand it so they would be best with someone else. That's what I thought in

my head, right. Never really came across it until this person, my first person that had a

severe disability in that way and was actually on disability for it, you know social

security disability. But because she was transgender and that's my specialty, I was like

I've got to stay with her, got to stay with her. Not sending her to somebody else because

nobody else is going to be able to take care of the gender piece.

CORTINA- I think my personal discomfort with it or with the term and with the

condition of disability, not the person, but I think it's hard for me personally especially

now that my brother has a disability and I have my own kids, to see people struggling

with disability. I think I may find it hard to move beyond feeling pity for them and being

able to engage with them in a different way than from pity. So that probably is a

challenge as to why I probably avoid the population, because my first personal reaction is

just like, I feel sadness, or I feel bad for them, I feel how unfortunate it is. And I guess as

a counselor, I don't wanna operate from that perspective with them. So I think I probably

avoid it.

FAITH- There's probably some people that are slightly on the spectrum that I've worked

with. Because I work primarily with adults I don't see it quite as often. Same thing with

the developmental disabilities is it's not quite too severe because in order for them to be

able to have the conversation and do actual therapy their developmental disabilities tend

to fall on the line of more of a mild and not quite as severe, just for what I've encountered

working with myself. I know there's others that are here that are a little bit more severe.

The reciprocity between the participants' negative attitudes and their initial lack

competence often explained the participants' lack of interest, exposure, education, and

confidence in disability issues. Moreover, participants commonly described the negative

reactions that emerged from holding these negative attitudes or biases. For instance, participants

consistently expressed initial reactions of fear, discomfort, frustration, and avoidance when

working with clients with disabilities. However, the evolution of counselors' compromises in the

work with clients with disabilities was explained by their ability for self-initiation.

Self-initiation. As the participants moved forward in their evolving compromises, they

expressed being more grounded in their role as professional counselors and in their commitment

to the population of clients with disabilities. These evolving compromises were reflected in the

participants' desire to get informed and demonstrate ***Self-Initiation*** in their learning. The self-

initiative expressed by the participants varied according to their possibilities for connection with

their learning communities. Gloria and Brittney decribed their initiative to acquire actualized and

clinically grounded knowledge. Eliza and DDD specificed the opportunities they take advantage

of (i.e., workshops, on-site resources, textbooks, peer-reviewed articles, and Internet sources)

when self-initiated to learn about the issues impacting their clients with disabilities. Moreover,

DDD is one of the few persons who sought out non-clinical knowledge.

GLORIA- I think you have to stay current, and you have to continually refresh yourself.

Even I'll go back and read old things again just to really have it at the forefront of my

head for dealing with issues.

BRITTNEY- I know for myself, like if I had a client who was diagnosed with something that I wasn't as familiar with or... We worked with a lot of clients especially in our program where not only their mental health was a huge issue, but their physical health was rapidly declining, severe diabetics who didn't have the cognitive ability to take care of their diabetes independently or clients who were extremely obese and continued to either eat cookies everyday for lunch or... One guy went to the extreme and ate nothing but Ice's for three months and his health declined because he wasn't getting enough nutrition. I feel like you can't depend on what you learned in the classrooms and what you've learned working with other clients. You have to do the research yourself.

ELIZA- [I attend] workshops that have been scheduled here. [I use] our training website. Many different avenues. We have whatever resources we have [on-site] and things like that. If there's ever any question, whether it's something that I can put my hands on as far as textbook material or seeking out support from staff. There's many different resources.

DDD- Google, and reading scholarly articles. Evidence-based peer review, but also sometimes just regular web pages and this serves as seeing people's experiences so I can hear it in different words. All of that type of research you can do that's official, like peer reviewed, and also unofficial, anecdotal research online or something like articles whatever that someone just wrote about their experience or whatever.

Therefore, as their compromises evolved, the participants increasingly expressed their responsibility for taking advantage of opportunities for learning about disabilities. Moreover, many participants positioned self-initiated learning as a way to disrupt the cycle of lack of competence emerging from initial negative attitudes. Self-initiative would also facilitate paths for growth and achievement of sense of purpose as professional counselors.

Sense of purpose. The participants identified the emerging *sense of purpose* as a fundamental aspect of the role of licensed professional counselors working with clients with disabilities. First, participants emphasized the need for personal work to occur. In this personal work, the counselor embraces the struggles, faces assumptions, recognizes privilege, and disrupts the discomfort and avoidance emerging from biases and stereotypes held by the counselor. Jerome and Natalie described the need for personal work in the following ways:

> JEROME- Going back to the idea, I really think that folks need to spend time doing the work in the trenches. Work with folks with lots of risk factors, don't go in thinking it's going to be easy, struggle. Some sense, you need to lose your assumptions and learn who you are, and then that allows you to learn who other people are. If you want to be a counselor, you have to have some ability naturally to engage people, and then you have to have the willingness to work on that. You have to have a willingness to take the feedback, apply it, open up and be vulnerable. The therapist's work is so important because you have to do the work yourself in order to help people do the work for themselves. It's about people can, again, I think it goes back to you can learn all the skills in the world, but if you haven't done the work, or aren't willing to do the work, it's going to be really hard for you to connect to people, and you're going to struggle, and you're going to struggle to be open to asking those questions, you're going to struggle with understanding people, you're going to struggle to connect with people. I think in some sense, that it goes back to do you not want to do the work for people? Is this being a therapist not a good fit? That's probably another topic altogether.

> NATALIE- There's no way you're going to step up, ever from that, until your own therapy […] be in your own therapy, be open-minded to anything that's going on in your

subconscious. Any judgments you may have about like why is that person like that. If you never have mental illness you might also be like why can't that person get out of bed? And you think oh, I'm not judging them, but that thought's in your head and you're just not recognizing it. You're not giving it a moment to say oh, this is what I'm feeling. You have to acknowledge our own feelings before we can really rise to the occasion and meet our patients really where they're at.

Second, some participants conveyed their sense of purpose and connection to clients with disabilities once they experience disabling experiences or became disabled themselves. Also, participants experienced an enhanced sense of purpose once they became aware and recognized the impact that other of their marginalized identities had in their personal life. Peter and Queen provided descriptions that exemplified their enhanced level of understanding and empathy for their disabled clients after realizing and processing the impact of disability in their personal lives. Unice further framed her experience of empathy for clients with disabilities who also shared her racial identity.

> PETER- I think that some of what makes me [competent] is that I, myself, have a disability. As a child I was dyslexic. I am dyslexic. The reason I say "was" is because dyslexia, depending on the person, when you mature into full adulthood, maturation meaning not necessarily emotional but physical, it gets less and less. I'm still dyslexic, but I don't have the kind of problems that I used to when I was a child. So as somebody who had a disability in the early 70s, who went to school when there were no services for individuals with disabilities, there was no such thing as an IEP, and individualized education plan, that didn't start until 1979 when they started to have committees on special education in the public schools. Now at the age that I am of 46 I have a physical

disability. I have problems, herniated disks, and things of that nature that cause me physical pain. It's not only on an academic level, whereas when I was a child I struggled with math and I struggled with reading and all of that other stuff, but now as an adult I can also see the angle of the physical disability, and how difficult it must be for somebody who has cerebral palsy who's using a walker or whatever.

QUEEN- One thing I hadn't mentioned on my intake form is that I ended up being diagnosed with post partum depression after my first child. The ADHD stuff hasn't been a huge impairment for me. I don't think I've really navigated through life seeing myself as a person with a disability related to that. I think just more so in more recent years where my environment has changed, I've felt a little bit more affected. Having post partum depression, my own family members who love me and are supportive of me really say, well, what could be that bad? What could be ... you got this new baby! Just that profound lack of understanding was so painful. I think recognizing how nuanced that can be has helped me be a little bit more empathic to people.

UNICE- I guess because I can relate with my clients, I am Hispanic as well; I can understand some of the struggles that they have encountered. I think that that helps me just keep pushing forward. I just have this desire to just give them that peace that they're longing for. Whether it's just helping them restructure their thoughts, it helps me because it keeps me aware of the constant daily work that has to be invested in order for us to be exactly where we want to be. Once I feel that I've reached a certain level, I just have this inner desire to just keep going, because I don't think it ever ends.

The ***sense of purpose*** was expressed by the participants in terms of the commitment to the professional role and the counseling work, which responds to personal values of meaning and

is intrinsically connected to the values of the profession. Jerome and Natalie commented on their intrinsic motivation to become their best professional self. Moreover, Unice expressed her beliefs around the meaning of helping relationships and healing connections represented by counselors in minority communities.

JEROME- I think what motivates me is that this is what I want to do, and so if this is what I want to do, and this is what people who do it tell me that's what you have to do to get there, then that's kind of what I jumped in.

NATALIE- It's just like suffering knows suffering and you just have this deep ... Part of me was like I'm going through my own suffering right now but I'll deal with that. I'll go to therapy and deal with that on my own time. When I'm in my session with my patient I'm there with them because that is my gut urge and desire and it almost feels like that's the reason I'm on this earth. It's not just a career, it's not money at all. It's actually so not about money. Could have done a lot less work for a lot more money.

UNICE I am a counselor because I want to help, because I want to alleviate some of the sadness or the maladaptive thinking that people sometimes ends up having for different reasons […] I know there are so little [Spanish speaking] therapists or counselors out there, individuals they can go to, I know that I have to find a way to keep going [...] I believe in what I do, I believe in the modality of treatment I provide because I have seen it work with individuals with disabilities and I share that with my clients. It is an investment we make together and in completing they experience positive benefits that have a lifelong effect.

The participants positioned the personal and professional ***sense of purpose*** as the ultimate result of their professional work. The satisfaction of helping others and representing hope for

disenfranchised communities was only achieved when counselors demonstrated initiative for learning and for to the cultivation of awareness. The participants grounded this awareness-building process in the necessary deconstruction and acknowledgment of privilege and biases that explained negative attitudes towards clients with disabilities.

Process variables for evolving compromises. Within the theme of evolving compromises, three process variables were initially identified as factors creating movement and synergies between the subthemes. Therefore, as the participants described their experiences, three dynamic factors were evident through their stories. These three process variables: reflexivity, time and development, and experience and exposure, are described below and substantiated with participants excerpts.

Reflexivity. One of the emerging process variables that participants consistently emphasized within this theme was the need for engaged and ongoing reflexivity in the work as licensed professional counselors. Thus, participants framed ***reflexivity*** as the ability to acknowledge their personal reactions and negative attitudes, and self-evaluate to identify areas for growth that would require more training and consultation. Sarah described the need for self-reflection in this manner,

> SARAH- It was a lot of personal - understanding why am I responding this way or why am I reacting this way? Is this a prejudice that I have? Is there - Really a lot of self-reflection on what I was doing and how I was feeling about the particular session. Was I feeling frustrated? Was I feeling helpless? So I think to have self-awareness and just being aware of how you feel.

and highlighted the importance of clarifying the roots of those reactions as a ongoing exercise in the work as a counselor. Along with the need for reflexivity, participants also highlighted the importance of personal maturation and development through time and lived experience.

   Time. Participants identified *time* as an activator of their development in the work with clients with disabilities given their own personal ***development*** and maturation process. Per their report, time facilitated the accrual of lived experiences that enhanced the capacity for empathic understanding of their clients' narratives, as the counselors got older. Brittney described her own process of growth "in the field," whereas Otilia made reference to her own process of aging and increased professional experience.

   BRITTNEY- I think just growing in the field. It's not something that you learn right

   away. I feel like you have to do it. Literally, you just have to do it, because you're not

   going to get anywhere if you don't.

   OTILIA- I think what helped me was, like you said, I did an internship. I did some more

   courses. I got older. I had more experience.

Along with the dimension of time as a process variable that fosters maturation and development for many counselors, the participants consistently highlighted the importance of clinical experience and exposure to clients with disabilities in order to galvanize counselors' evolving compromises.

   Experience and exposure. An additional factor impacting the context or the process of evolving compromises was ***experience and exposure*** to clientele with disabilities and a variety of community settings that serve this population. Jerome described the importance for real world experience along with optimal clinical supervision in the transition from initial negative attitudes

to the achievement of sense of purpose. Moreover, Unice stressed the importance of exposure to a variety of clinical settings that serve the population of clients with disabilities.

JEROME- It's really hard to talk about certain skills. I think you have to have good, you have to be out in the real world and get real world experience. I think you have to put yourself out there to get some real experience about things, and I think other than that, and then you need good supervision. If you can get out there in the real world and get supervision, I'm not really sure you could take a class on it.

UNICE- I think [what has helped me is] my own experiences. I have worked with different agencies with different interests or focus, and that has given me an additional education. It's not just the institutions that have been able to educate me, but has also been my own personal experiences in different environments. For example, I worked with [name of agency], they are a non-profit agency who offers supported housing for adults with mental disabilities. In that environment, I was able to work one-on-one with individuals, adults, Hispanic population, that was faced with limitations. I had more flexibility because it was such a different environment in incorporating different techniques with them. In that environment, I was able to go into their homes and show them how to utilize certain skills. That gave me, once I started seeing them able to incorporate some of these skills, that motivated me and I knew that there was help for them. I knew that I was able to offer assistance on different levels. Then I went to work with another non-profit agency that focused on domestic violence and sexual assault and rape. I was able, again, to work with the Hispanic population. Then there was a collaboration that we did with Head Start program in [city], and I was able to provide counseling in a safer environment for the adults, for the parents. A lot of these parents,

again, came with a lot of limitations education-wise, physically. Through repetition,

constant consistency, I was able to see them actually absorb and understand.

Within the theme of **evolving compromises**, and as it is evident in Figure 4, the process

variables of reflexivity, time, and experience and exposure to clients with disabilities were

initially identified as factors creating interactions between the subthemes of negative attitudes,

self-initiative, and sense of purpose. As a whole, the theme of evolving compromises illustrates

the counselors' transition from earlier stages of emotional reactivity to their clients with

disabilities, to more advanced and clinically grounded stages of therapeutic work that strongly

inform the participants' competence to work with clients with disabilities. The following

identified theme presents the preliminary components of **competence** based on the participants'

experiences in the work with this population.

Competence

The participants described multiple components that are embedded in the emerging

concept of competence. A few participants expressed the separation between multicultural

competence (MC) and competence to work with clients with disabilities. For these participants,

the competence associated to disability would require specialized knowledge, skills, and levels of

awareness that would extend beyond the established ideas of multiculturalism within the

counseling profession. For these participants, disability was mostly considered a medical and

clinical issue that required different expertise and skills. However, the majority of the

participants reported a strong relationship between MC and competence related to disability. For

them, the competence to work with clients with disabilities is then defined as part of MC, which

requires deeper and more engaged approaches to diversity in order to embrace and address

disability as an aspect of multiculturalism within counseling. Within this theme, competence is

preliminary explained by four identified subthemes: ***Disability as a cultural group***, counselor's ***consciousness***, ***interrelated work***, and ***dimensions of oppression***. Across this theme, a preliminary process variable was identified: ***Becoming vs. overcoming***. Figure 5 presents a description of the sub-categories of **Competence**.
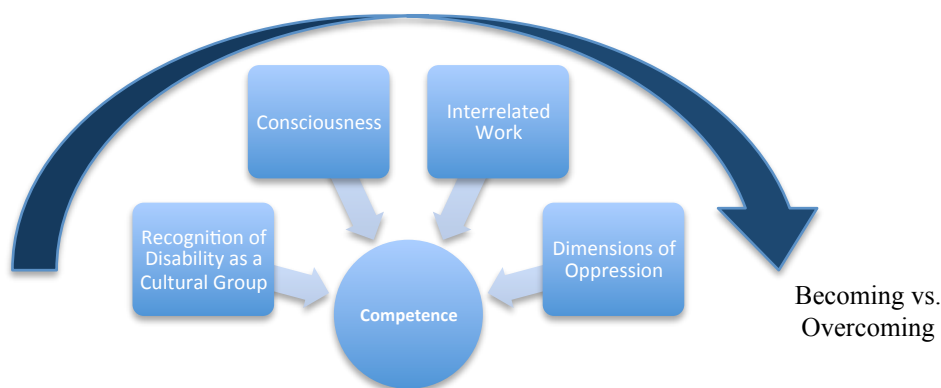
Figure 5. Competence

Recognition of disability as a cultural group. For participants, ***disability is recognized as a cultural group*** given that it is taught as part of multicultural curriculum. Participants recognized the uniqueness of this cultural group and stressed the need for grounding commitments and respect for difference that are specific to this population. Lynn and Henry described this in the following ways:

> LYNN- I definitely think that they are related. I think disability and in particular the culture of disability, and even more specific the culture of various disabilities, falls under the umbrella of culture, but I think that the things that fall under the umbrella of culture, it's getting a little crowded under there.
>
> HENRY- We really do not give working with disabilities enough time. I think that needs more. I think as opposed to trying to infuse working with individuals with disabilities into multicultural training, I think having it's own separate training, specifically about

individuals with disabilities. Then it's own separate training about specific individuals with disabilities, like part individuals that may be Hispanic or individuals of eastern backgrounds or individuals of African American descent. If we could actually have specific trainings in regards to each I think that would be great. Because I think, I just don't think that there's enough training.

Moreover, participants described disability as one aspect of identity that is intersecting with other multicultural variables. According to their descriptions, these intersections determine the access to services, the living conditions, and wellness opportunities for these clients and their families. Even though participants did not offer descriptions around the historicity or politization of identities, they actively mentioned race, social class, immigration status, and affectual orientation as dimensions of identity that complexify the clients' living circumstances and which directly impact the counseling work. Natalie described the complexities of the work with clients who experience the amplified effects of marginalization because of being disabled and transgender. Gloria, Sarah, and Unice named the interplay between social class, education level, immigration status, and language, along with their impact on disabled clients' lives.

NATALIE- Then I have to deal with, whether it's in private practice or at the college, is basically how whatever their disability is, is now intersecting not only with their identities but with their other mental health conditions. If they have anxiety and depression, if they have bipolar, if they have […], like just pretty much any other thing in the DSM. Then you have the extra layer of someone being part of the LGBTQ community where they're already in a position of being in a marginalized population for being a disabled person in some way, shape, or form and then you add on that layer of oppressed identity like being transgender.

GLORIA- For instance, I work with a family, I see the two young children in play therapy and the mom has lost custody of them. She definitely has some serious mental illness, it's a very strong reason why the court decided that she only has supervised visitation, but she's a different ethnicity and a foreigner in this country than the father, and I have met with her a few times, and it was a very humbling experience to see that she was very marginalized. She was not only somebody who didn't really speak the language, didn't know the court system, didn't know the rules of sort of parenting in this country, what was acceptable and not acceptable, and had minimal education, and who felt like she was manipulated by the system, or tried to manipulate it in a way that felt comfortable for her. There were so many variables, and also being a mother who's had her children taken away from her.

SARAH- The problem is, for example, if I'm working with, let's just say a Hispanic female from Mexico who has a disability - Well, all right, so I did have an elderly Mexican woman, whose only language was Spanish, and she had renal failure. She had severe diabetes and things like that which were disabling for her. Her coming from a single - she was the breadwinner of her family for many years because her husband had been deported. She was here legally but she had kids and grandkids who were not here legally. It opens up a whole entire - She felt very disempowered, even though she was here legally. There's still a lot of fear of doctors and medicine and "Am I going to get deported?" There are so many other factors that play into everything. She didn't like to ask for help. She didn't feel like she deserved it.

UNICE- Sometimes when a client is of Hispanic descent who lacks education, for example I have one client right now who cannot read or write, so some of the handouts or

information that I want her to review […] I can't do that with her [because they are in English], so I have to be creative and find other ways that some times take a little bit longer, so it get's done, but it takes a little bit longer […] sometimes it is not only the cognitive part but their legal status that, there is like no direction, sometimes the agencies, the resources, they are limited on language as well, the information that my clients are being provided is not to a level of their understanding so there is a long, uhm, it's.. I am trying to find the right word […] I just start to think about the work with my clients and I am just remembering how sometimes they would go to different resources whether it is the schools, for their children, or for their immigration status, and they would be frustrated because they would be provided all this information and they feel overwhelmed, their level of fear is, I can't even speak on it, because their level of fear is you know, unimaginable and to be able to trust me with some of this personal information, for them is very difficult, so it is frustrating for me because sometimes, I am not fully aware of the process you know, that some of these other entities can provide, so sometimes, again, I am involved on so many different levels, not just counseling the individual but sometimes it is helping them understand some of these other aspects that affect our work, that affect the treatment, so sometimes I find myself in a lot of different directions, you know, to assist them, and sometimes that is overwhelming for me […] sometimes it creates a lot of work and a lot of avenues that I wasn't prepared for.

The participants described the recognition of disability as a cultural identity that intersects with other identities, and considered it an important manifestation of competence in their work as professional counselors. This recognition not only highlighted the unique cultural aspects of this identity, but it also juxtaposed with other identities that would determine the

resulting conditions for resiliency and wellness of clients. An additional manifestation of competence in the work with clients with disabilities was consciousness.

Consciousness. When mentioning the necessary skills and conditions for the effective work with clients with disabilities and in relation to the needed personal work to achieve sense of purpose (within previous theme), the participants mentioned the importance of ***consciousness*** around this cultural group. Some participants emphasized the need to understand beforehand the nature of the work to foster preparation and commitment as a professional counselor to clients with disabilities as well as any other cultural group. Specifically, Jerome and Brittney highlighted the need to be conscious about the intricacies of the work pertaining to clients with disabilities.

> JEROME- I think a lot of times you have to be cognizant of folk's risk factors, or cognizant of culture, or cognizant of disability. You have to keep that in your awareness. It's snowing outside today. If I go for a drive, I need to know it's snowing. If I drive outside like it's summer, I'm going to be very rudely awakening. You keep that in your mind. You don't necessarily don't drive, right? You still go out in the snow, you just use caution. It's being aware of how the factors impact things.
>
> BRITTNEY- Yeah, you have to keep an open mind and realize that this is what you signed up to do, you know, this is what you went to school for, this is what you worked hard for, this is what you signed up for, and you can't say, "I'm not working with that person because they don't speak my language. I'm not working with that person because they're drug addicts, or because they look scary, or because they wear the same clothes everyday."

Participants described consciousness in terms of being prepared and willing to take the necessary steps to overcome the lack of knowledge or the counselor's personal reactions emerging in the interactions with their clients. Thus, consciousness is fostered through the engagement in reflexive practices as licensed professional counselors. Moreover, the dimension of consciousness about the work with clients with disabilities also informs the decision making for steps towards collaboration and connection with the professional community through interrelated work.

Interrelated work. In congruence with the previous theme of "It takes a village," participants also mentioned the importance for ***interrelated work*** that goes beyond the counseling room and includes organizations, institutions, and communities of disabled advocates for generating competence. Participants highlighted the importance of the interrelated work as counselors not only for collaboration and consultation with the professional community in the "village," but more specifically in terms of the intentional immersion of the counselor in the client's community. For instance, Lynn highlighted the ability to build coalitions with the disabled community to foster the interrelated work for clients with disabilities.

> LYNN- I think that too often, from my perspective, when communities are building coalitions for example to work on mental health issues, I think that having representatives of people who work with the disability community is sometimes an afterthought. They're not always present in those coalitions, and I think that that is really problematic. I was just lucky. It wasn't anything that I did, but I was just lucky that I was in a community that did recognize that and have that presence. That was helpful.

Along with the importance for consciousness as an expression of competence, the participants highlighted the need for collaborative and interrelated work that extends beyond the

boundaries of the counseling office and the professional community. Counselors described the necessity for interrelated approaches that link the counseling work with the client's immediate communities. Thus, counselors need to become knowledgeable of the community organizations focused on disability issues as well as aware of the oppressive dynamics that have historically impacted the disabled community, and have informed the emergence of social movements and political organizations.

Dimensions of oppression. Moreover, in order to develop competence, participants commented on the need for counselors to develop expertise and sensitivity around legal and historical *dimensions of oppression* that have defined the history of disenfranchisement of disabled groups, the issues around access and accommodations, as well as the pervasive impact of medicalized narratives of identity. As professional counselors, some participants also stressed the need for self-advocacy to become a dimension of intervention. DDD and Queen described this in the following ways,

> DDD- We have a lot of people telling them things and helping them where they may or may not need the help or understand the help. I try to think, as well, what have they experienced on an institutional level because of their disability, what do they experience from society, how does that impact the way that they are perceiving our time together, and what can I do to make sure that I am taking that into account as I inform myself of my next decision or intervention.

> QUEEN- I think being able ... well having an understanding, having a solid understanding about the disabilities rights movement and how that impacts people to access systems that they may or may not work with. I think understanding how to navigate local community systems, assisting people in learning self advocacy, which I

think honestly is probably the best work I've done, is really supporting people and understanding how they advocate for themselves.

In terms of dimensions of oppression, participants commented on the need to cultivate awareness about the clients' experiences with the mental health system that defined how the clients perceived the counseling work. Participants emphasized that counselors, as part of the mental health system, need to interrupt potential oppressive practices that can unintentionally be perpetuated in the counseling work. Therefore, counselors need to be mindful about what narratives that are privileged in the counseling work with clients with disabilities. Given that this variable seemed to influence the whole theme of competence, the counseling focus on becoming vs. overcoming is described below as a process variable within the theme of **competence**.

Process variable of becoming vs. overcoming. Finally, the counseling focus ***becoming vs. overcoming*** was identified as a process variable within this theme given its precipitating effect for competence that is grounded in human dignity and wellness. Some participants described the importance of overcoming issues of adjustment and loss embedded in the disability experience and overcoming them in order to function in more normative ways. However, the majority of the participants emphasized that as professional counselors, the work around these issues must be grounded in ideas of wellness and resiliency for clients to become their best selves and live full lives. Therefore, counselors are called to attend the balance in this differential focus within their professional work. Queen and Sarah commented on their understanding of disability as tied to narratives of grief and loss. Moreover, Sarah and Allison emphasized the importance for the clients to use their resources to become their best selves.

QUEEN- I found [and elective taken in graduate program] to be a really helpful base to understand, at times, the loss, the grief process that can sometimes be associated with [disability].

SARAH- And at the same time they both have grief and loss issues related to their inabilities to do certain tasks and things like that. So really helping them come to terms, I think, with their disability and what that means for them, as far as their capabilities and their functioning level, things like that, is always an important place for me.

ALLISON- The only reason why I have been able to help people is because of just my curiosity and why do people do what they do? How can I, because this is what I wanna do, help somebody? How do I get them to see their potential and what they can do for themselves? Because I think everybody have that power, even if you are disabled. You could still do things maybe it's different than what you imagined. But as a therapist, that's your role is at least to me is to show somebody, just because I have this road block, it doesn't mean it needs to really disable me, you know?

The counseling focus of becoming vs. overcoming seemed to inform all areas of competence to work with clients with disabilities. As it is evident in Figure 5, the focus on wellness and human dignity for the clients to become their best selves based on their level of ability and unique circumstances seemed to propelled the manifestation of competence. Thus, the focus on becoming influences the counselors' ability to recognize disability as a cultural group as and develop consciousness by coming to terms with their own assumptions. Moreover, the focus on becoming also informs counselors' ability to engage in collaborative and meaningful interrelated work that extends beyond the counseling room, and recognize the dimensions of oppression impacting their clients' lives. Through this dimensionalized conceptualization of

competence, the counseling work touches upon systemic issues that inform clients' issues. The final theme, Systemic Dimensions, was identified as emerging throughout the whole narratives of participants and is presented as the last theme in this emerging analysis.

Systemic dimensions

      The participants mentioned different systemic issues and dynamics that directly impact the work with clients with disabilities from the perspective of the client and the counselor. Participants described presence of systemic structures and demands that disempower clients, perpetuate and increase stigma, make disability invisible, and demand counselors for increased productivity. Within this theme, four subthemes were identified: system representing a *double bind*, *prejudice and stigma*, the *silence of disability* in curriculum and post-graduation training, and the issues around *productivity in the mental health system*. Figure 6 presents a description of the sub-categories of **systemic dimensions**.
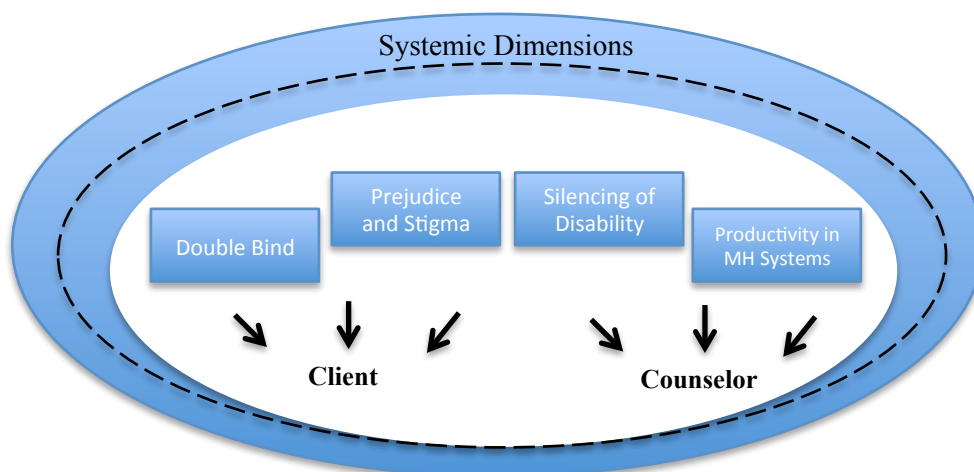
Figure 6. Systemic Dimensions

      Double bind. Some participants described the tension between a community of professionals that steps in to meet the needs of clients with disabilities (enacting paternalism and disenfranchisement), but also becomes distant and hard to navigate for clients who are trying to

have their needs met by the system. According to the participants, this ***double bind*** dynamic

further disenfranchises, disempowers, and removes the initiative of disabled clients. Tela

commented on the quandary present in her clinical practice between the betterment of clients'

lives while being able to maintain government benefits to secure the coverage of some basic

needs.

> TELA- I think there's also an element where, the two folks I'm thinking of, are highly
>
> integrated into the system so there is case managers, there's people that provide
>
> transportation, there's a lot of support with them and so I think in some ways, there's then
>
> ... Not as much ability to Figure things out on their own. There's a lot of support that kind
>
> of takes care of a lot of life's challenges that otherwise they might be able to process
>
> things a little more. I think there's definitely some ability there that is undermined by a
>
> certain level of continual care. […] I think we also have a system where if someone is on
>
> disability, there are actually ... They have to stay sick to get benefits and so I think that's a
>
> really bad system. It's hard to tell where wellness is in that and how much wellness is
>
> achievable. I think as a therapist, it's really hard to ... See what progress is in a system
>
> that actually progress is detrimental to their well-being or to the long-term maybe
>
> financial ability of the person.

Participants not only defined this double bind as problematic and unjust, but also

recognized the importance of continuous and consistent care represented by the client's

connection to the system. The participants recognized their professional role as pertaining to that

system that helps the client but that also, as a whole, might remove their initiative. Thus, the

participants reflected on the importance of gaining awareness about the dynamics surrounding

their positionality in the mental health system. Another systemic dimension impacting

counselors' perceptions of their development of competence to work with this population was

the silence surrounding disability.

Silencing of disability. Another systemic factor impacting the work of LPCs is the

silencing of disability in training standards, required continual education requirements, and

community representation (i.e., co-facilitators, faculty). This silence of disability in the training

not only represents a lack of preparation for the counselor but also a disservice to the overall

community of clients and counselors. Natalie and Gloria commented on the potentially

detrimental consequences that emerge from the absence of disability contents in their training.

Moreover, Lynn described the enriching experience from being exposed to faculty or other

students with disabilities and inclusive learning throughout her training.

> NATALIE- That's why I really felt like [my] program was a disservice; it did a huge
>
> disservice to the community of clinicians who are now working on [name of city] or
>
> wherever they moved to. Where they're not having any awareness of their personal
>
> biases, just like I know I have bias. I work with it everyday. I see it in myself. I work with
>
> people with disabilities and I judge them. Absolutely. I can't control my brain. We can't
>
> control our brains, that's what people think they can. We can't control our subconscious
>
> mind and our subconscious will sometimes throw a thought across the brain like […]
>
> eww, I just thought that, that's gross. I don't want to be like a discriminatory person but if
>
> you don't pay attention to that thought, you dismiss it, and you think you're just this open-
>
> minded all the time, oh my god I don't see color, I don't see disability, I don't see
>
> anything, you are doing a huge disservice to your patient. […] To get the training you just
>
> need professors that actually have experience working with these people, either clinically

or really just have a lot of experience with people in general. Or professors that can speak

to their own selves.

GLORIA- I can talk about to my training, I feel like in my training, we talked a lot about

multicultural issues, several courses on it, but there definitely was not a course on

disabilities and working with people with disabilities, and I think that you could apply the

same kinds of ideas and theories to it. If you look at Asperger's and say, "Okay they

speak a different language. They have a different perspective. They're coming from a

different place and you have to know it." That would be an interesting conversation to

have with people. I don't see it being done really, unless people seek it out.

LYNN- When I was doing my master's degree in counseling, we took two courses on

working with students with disability. Both were taught by faculty who had disabilities.

One class, my instructor was blind and had some physical disabilities. In my other class,

there were two instructors, and one of them had a traumatic brain injury and resulting

speech difficulties. In those classes, not only were we working in the community with

students who had a variety of different special needs, and we were in those classrooms,

so we were working with different types of tactile and different kinds of oral stimulation

to help with speech and things like that.

The majority of the participants described the silence of disability trainings, discussions,

and representation that they have experienced in their professional practice. Many participants

further reflected on the lack of institutional trainings (i.e., workshops) and professional

presentations (i.e., conference presentations) focused on disability issues. Additionally,

participants juxtaposed this silence to their difficulties to engage in further exploration of

learning opportunities given the lack of time and energy resulting from excessive demands for productivity in their sites of employment.

 Productivity in systems of mental health. Also, participants manifested the realities of expectations and demands in terms of ***productivity in systems of mental health*** that compromise counselors' use of time and resources to cover required CEUs, demand the handling of big caseloads, and increasingly requires evidenced-based outcomes that increase occupational stress for low compensation. Otilia described the pressures for productivity through big caseloads, the demand to show the success of counseling interventions, as well as the lack of time and resources to have access to further learning opportunities. Also, Allison highlighted the contrast between high demands for productivity and low compensation for her personal investment in the work of a counselor.

  OTILIA- […] my caseload is always full. There's a wait list. There's not enough time in the week it just seems. For the kids, community violence, kids being exposed to trauma. Working once a week for 40 minutes sometimes just isn't enough […] Sometimes, I think I could just run a trauma group. I wish there was more time to focus on kids. Instead of having a huge caseload, having a smaller caseload and providing more intensive therapy to the kids and families. Sometimes we don't see parents for once every two or three months whereas they could probably benefit from family therapy once a week. We just don't have that ability. I think that's a huge challenge in this setting. […] I think also [what helps is] more research and more knowledge on things. You learn in school that X, Y, and Z works with a kid who has a reading disability or a learning disability. What if you do X, Y, and Z and that doesn't work? Then what do you do? You know, you've got pressure on you to show success with these kids in this setting. What do you do when that

doesn't work? Then what? Things like that also would be beneficial I guess. [Also,] it's

hard to get that training in. I got an email yesterday saying we have to do 36 hours of CE

in three years. I'm like, "Well at [name of agency] you have to pay for your own training.

You have to take your own personal time for that." For me, I have issues with that

because I don't make a lot of money. I have a big family. It's hard for me to pay $200 to

go to a training. It's like if that was provided more across the board, I think people would

feel more comfortable in direction and skills off the bat.

ALLISON- Yeah. I definitely have moments where I don't know if I wanna just do

therapy with people anymore, because it's a lot on a person. I've definitely had thoughts

of, "Do I really wanna do this?" There are times when you're just like, this is a lot. It is a

lot and we don't really get compensated for working. So it's really challenging.

One participant expressed that another systemic demand related to productivity was the

need to coordinate and perform additional work as a bilingual counselor. As a Spanish-speaking

counselor, I deemed this participant's comment to powerfully demonstrate the nuances of the

professional work when we embody non-dominant identities. Unice explained that given the

dearth of materials and resources in Spanish, she needs to spend additional time during the day in

tailoring these materials. Having to self-initiate in this regard in order to facilitate the availability

of resources for her clients represented an additional time and energy investment that is not

necessarily reflected in her billable units for productivity as an employee.

UNICE- Because my clients have other demands [language] it becomes a little bit more

difficult so sometimes I feel like I am doing a lot of extra work, again just to be able to

provide them with the treatment that they need in a way that is going to be absorbed in a

healthy way for them. […] One of my personal frustrations, you know my colleagues,

sometimes they don't realize and my colleagues, you know, and I know that they don't mean it with any kind if ill-will, but sometimes they are like oh, you shouldn't be so tired, we do this every single day, and I think to myself, we don't do the same thing every single day, I have two very distinct roles, and you know, I find myself more mentally exhausted because I have to switch my language back and forth and that takes a lot of time. [However] I seek to find support on them to bounce ideas back and forth about my clients.

When reflecting about the pressures for productivity in the mental health system, the participants described these as discouraging and unfair given the level of emotional investment required in the work of a counselor. Participants further commented on how their lack of time and energy directly impacted the quality of the work with clients with disabilities, as well as the counselor's opportunities for learning. A final systemic dimension impacting the participants' perceptions of their development of competence was prejudice and stigma.

Prejudice and stigma. Another systemic aspect encountered in the work with clients with disabilities is the ***prejudice and stigma*** that surrounds this identity. Per the participants' report, prejudice and stigma surrounding disability commonly informed people's reactions to this population and fostered disengagement of clients from services they don't feel as theirs. Maria commented on the problematic assumptions that surround chronic illnesses. Queen described her views of some racial groups experiencing increased levels of shame when a family member has a disability. Also, Lynn reported her experiences of seeing institutional prejudice and stigma enacted through the disbelief of clients with developmental disabilities who reported sexual abuse.

MARIA- Just seeing people getting taken advantage of, I think. Again, I always have to draw on my own experiences, and things that have happened to me as I've gone along with my own illness, especially when you're talking about invisible chronic illnesses. It's very easy for someone to say, "Hey, you're fat. You should lose weight." or "Why are you on that scooter?" I've gotten yelled at because I have a disability placard for my car and I've had people yell at me that are older. "Why do you have that? There's nothing wrong with you." and I'm two weeks out from having major surgery. Seeing those things and seeing how that has organically affected my clients in understanding how painful that can be, has helped me look at them very differently.

QUEEN- Related to some of the people I've worked with visible disabilities, I think I found in African American communities, people seemed to have a lot more familial support, extended family support, for those that I happened to work with. […] I think I've found that more of my white middle class students think they're held in ... there's probably even more stigma reinforced in that family because the families aren't necessarily talking about what's going on and they're trying to keep things, there's an appearance of them trying to keep things more private. There's this stoic responsibility on the parents' part and some of these things that are out there, I think I've found.

LYNN- [another factor] I guess, is that a lot of them [clients with intellectual disabilities who are victims of sexual abuse] had reported to various people what had happened but were not necessarily believed. I would say that's mostly the case for the clients that had intellectual disabilities. It took a long time for people to hear and to really believe what they were saying, and to believe that they could possibly benefit from any support from it. I had this one client who I worked with for a long time. He had very severe autism. He

was nonverbal, and his mom who would come with him, who was just an incredibly

lovely, loving woman, had known about what had happened. She'd reported it to the

authorities. She'd done all the things that we would want an involved parent to do, but it

was years later when she even thought that there might be something that could help him,

because she basically saw counseling as not for him. He had a behavioral interventionist,

but in terms of any kind of emotionally based support, she just never saw it as an option.

The participants overall described the experiences of prejudice and stigma faced by their

clients in different systemic realms, and further highlighted the need to represent exceptions to

these systemic dynamics. However, participants also expressed increased discouragement from

the increased productivity demands in their sites of professional practice. Therefore, and as

evidenced in Figure 6, these systemic dimensions impact the clients and the counselors at the

same time.

Triangulation and Discussion of Initial Themes Identified

Once the first round of interviews was completed, five emerging categories were

identified: **The therapeutic work**; **"it takes a village;" evolving compromises**; **competence**;

and, **systemic dimensions**. These categories were identified as the emerging descriptors of the

participants' perceptions of their development of competence to work with clients with

disabilities. See Figure 7 for a comprehensive representation of the preliminary categories from

first round of interviews.

Moreover, once these categories were substantiated through grounding in the literature

and peer debriefing with my research team, I proceeded to generate a summary to establish them

as the categories that would be further discussed with my participants during the first interpretive

dialogue interview. This emerging analysis document can be found in Appendix G. In the

following paragraphs, I attempt to synthesize my emerging conceptualizations of each of these categories or themes.

The Therapeutic Work	"It Takes a Village"	Evolving Compromises	Competence	Systemic Dimensions
Disability as Identity	Collaborative Relationships	Negative Attitudes	Disability as a Cultural Group	Double Bind
Counseling Relationship	Learning Communities	Self-Initiatiated Learning	Consciousness	Silencing of Disability
Tailoring the Approach	Clients/ Families Narratives	Sense of Purpose	Interrelated Work	Productivity on System of MH
		Experience/ Exposure	Dimensions of Oppression	Prejudice/Stigma

Reflexivity Time/ Development

Becoming vs. Overcoming

Figure 7. Preliminary Categories from First Round of Interviews

The participants described **the therapeutic work** with clients with disabilities as unique in ways that require counselors to understand the client's disability and the interactions between the disability and the client's presenting problem that is causing mental distress. In this process, participants acknowledged they initially attempted to understand the nature of the client's disability. According to Goodley and Lawthom (2006), disability has been historically associated with a variety of impairment groups that include physical, learning, sensory, cognitive, and mental health issues. Even though some participants shared this comprehensive view of disability, the majority of them expressed confusion around the boundaries of this minority group. In other words, participants made reference to the fluctuating boundaries of disability as a diagnostic category versus a social construction. Moreover, participants emphasized the value of

the connection to and engagement of the client through the therapeutic relationship and a personalized approach to their therapeutic needs.

In realizing the steps needed to tailor the approach to the work with these clients, the participants highlighted the value of a community that serves as a foundation for the counseling work. The role and participation of this community was described by some participants in terms of **"it takes a village"** and collaborative work to create change. This community seems to be grounded in the cooperative and participative influences of supervisors, peers, mentors, other mental health professionals and caseworkers. The participants frequently conveyed appreciation for the individualized and group support obtained in their places of practice.

Along with these collaborative relationships, the participants also valued their learning communities that supported them with trainings, workshops, conferences, and other resources to learn about this identity and tailor their approach in the work with them. According to Ratts and Pedersen (2014), the counseling profession is increasingly moving towards the recognition of community and contextual factors impacting the lives of clients. Moreover, Olkin and Pledger (2003) highlighted the need to include personal accounts of lived experiences from people with disabilities when theorizing about them. The participants highlighted the importance of collaboration with clients and families in the attempt to understand their needs and establish the goals of the counseling work. Being part of this village also generated certain processes for counselors. The ongoing collaboration and consultation in the work as a counselor created the development of closed communities of support described as circles of trust, as well as specialized knowledge or expertise around certain issues.

Moreover, as participants encountered clients with disabilities in their clinical practice and engaged them though tailored approaches sustained by a collaborative community of

support, the participants experienced shifting processes that will eventually lead to competence. Specifically, through exposure, time, and ongoing reflexivity, the participants developed **evolving compromises** towards their role as professional counselors and towards the population of clients with disabilities. Watt et al. (2009) and Olkin and Pledger (2003) explained the impact of clinician's narrow able-bodied perspectives on the ability to understand the clients' presenting needs and demonstrate cultural competence to appropriately serve them. In the process of their evolving compromises, the participants transitioned from avoiding and having negative attitudes about clients with disabilities towards a more robust demonstration of their professional commitments. This process was significantly influenced by the exposure to clients and different agencies that serve this population.

Therefore, the transition from negative attitudes to a more affirmative stance towards this population defined self-initiation and ultimately, professional sense of purpose in the participants. For them, the sense of purpose was reflected in clinical practice when they were able to cultivate a heightened consciousness through personal work and/or when they embodied a disabled identity themselves or another minority identity (i.e., Hispanic). The personal work was described by the participants as the ability to process, understand, and disrupt enacted power dynamics related to held privileges. Some participants described this as the main route to strengthen and galvanize their potential as professional counselors based on their commitments to the professional role and their disabled clients.

According to the participants' descriptions, these evolving commitments seem to set the ground for counselors to generate **competence** to work with clients with disabilities. Reeve (2000, 2006) highlighted the need for counselors to contextualize their work in historical and political dimensions of disability and actively encouraged counselors to expand and diversify the

conceptualizations of disability services to address the psychological effects of living in a disabling society. In congruence with Reeve's assertions, the participants stressed the importance for recognizing disability as a cultural group with particular historical dimensions and oppressive roots that are shared with other marginalized identities. Furthermore, even when participants related this competence to overall multicultural competence, many participants stressed the need for increased consciousness to understand the psychological particularities of disablement from a perspective grounded in wellness, resiliency and prevention.

Throughout the interviews, participants alluded to the presence of overarching factors that created and sustained certain conditions for clients and counselors. The participants described these **systemic dimensions** of the counseling work with clients with disabilities as overarching dynamics that disempower clients, remove their initiative for coping and wellness, and further perpetuate stigmatizing views of their functioning. Additionally, in congruence with Smart and Smart's (2006) assertions of the lack of representation of disability in counselor training and curriculum, participants identified the lack of representation of disability in their learning communities. Finally, participants described the demands for productivity in their particular settings of employment, which at times compromised their ability to engage in their learning communities and learn from their collaborative relationships. One example of this is the counselors having to work with disabled clients who do not speak English. In these cases, the counselors also have to navigate the demands of translating and tailoring their resources before using them with their clients; not only taking additional time from their schedules, but also having this not recognized as billable work.

Emerging Grounded Theory Reflections

I embarked in the initial identification of categories and their corresponding dimensions and properties during the first round of interviews through a process of constant comparison between the interactions with the participants and the evolving analysis (Corbin & Strauss, 2015). As a researcher interested in capturing and co-constructing a theory related to counselors' perceptions of their development of competence to work with clients with disabilities, I went out to the field to gather information from the participants through interviews, into the analysis of the data, back to the participants to collect more information, back to the analysis of the data, and so forth. This process not only afforded me the basis for theory development but also the process to strive for complexity in the construction of theory (Hays & Singh, 2012).

As I began to grapple with the emerging categories and their sub-categories through open and axial coding, I started to identify and illuminate emerging relationships that would lead to the conceptualization of their particular properties and dimensions. I felt encouraged to remain open and flexible to allow categories with their dimension, and ultimately theory, to manifest themselves. Figure 8 represents the dynamics behind the identified categories and their dimensions that pertain to the perceptions of their development of competence to work with clients with disabilities, as my participants experienced it.

Throughout the first round of interview process, my understanding of these categories, dimensions, and the emerging dynamics between them was still emerging. Therefore, Figure 8 is an attempt to capture my conceptualization of these dynamics in that particular moment. Moreover, as I engaged my participants in the interviews, they also acknowledged to be transitioning their own process of realizations and reflections around disability as an identity they work with. In the continuous engagement in further rounds of interview our shared

understanding evolved in ways that further clarified and refined the emerging categories, dimensions, and dynamics and led to the construction of theory about counselors' perceptions of their development of competence to work with clients with disabilities.
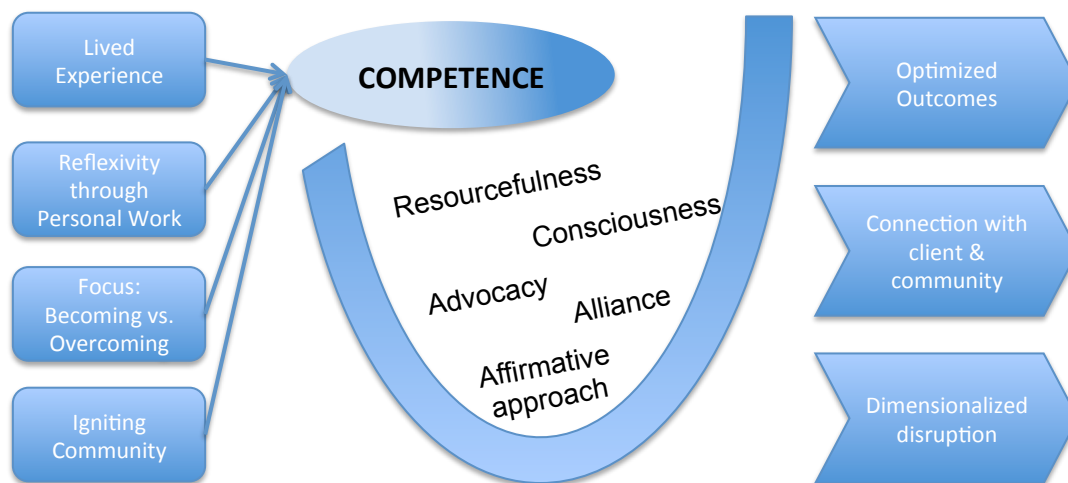
Figure 8. Emerging Dynamics in the Development of Competence

After completing the first round of interviews, it was clear that competence to work with clients with disabilities was dimensionalized to include resourcefulness, consciousness, advocacy alliance, and affirmative approach. The eventual competence to work with clients with disabilities would be manifested through the presence of optimized outcomes that are evidenced in the client's improved emotional, behavioral, and social functioning. Also, this competence facilitated the connection between the counselor and the client not only through the individual counseling relationship but also through connections that go beyond the counseling room, the agency, and reach the client and counselor's community. Additionally, the participants' perception of competence to work with disability further facilitated the disruption of pathologizing and further marginalizing narratives in different dimensions. For instance, these narratives would be disrupted through the counseling work in the client's life, their family

dynamics, agency operation, and community engagement. This dimensionalized disruption effect is grounded in values of wellness, prevention, and resiliency.

The ways how the participants described their experiences and my reciprocal engagement with the emerging analysis led me to identify process variables or precipitating factors for this competence to be reflected in clinical practice. These identified factors are lived experience, reflexivity, counseling focus, and the presence of an igniting community. Future data collection facilitated the elucidation of the connection between these process variables and the development of competence to work with clients with disabilities. For instance, participants identified lived experience to be related to personal growth and aging, as well as the personal impact of disability. This was captured in the overall analysis as the sub-category *sense of purpose* given that this was considered the outcome from personal work. Therefore, further clarification of the dynamics between lived experience and the development of competence to work with clients with disabilities required additional questions pertaining to the nature of personal experiences with disability and the counselor's maturation process impacting clinical practice. One example of these questions was, "How do your personal experiences of development/with disability influence your competence to work with clients with disabilities?"

Also, participants identified counselor's ongoing reflexivity and awareness of privileges to serve as a catalyst for the development of conscious engagement in the professional role and with the population of clients with disabilities. This emerging process variable was previously described in the category **evolving compromises**. Further data collection around the connection between reflexivity and competence to work with clients with disabilities was facilitated by generating follow-up questions related to the intricacies of self-reflection and cultural consciousness of counselors and their impact on the dimensions of competence to work with

clients with disabilities. This was facilitated by asking questions such as, "How do you see your power and privilege influencing your ability to work with clients with disabilities? In what ways have these helped? In what ways have these hindered your process?"

In regards to the focus on becoming versus overcoming, which was previously described in the category of **competence**, participants manifested tension between their medicalized training and job demands (i.e., billing, diagnosing) that informed overcoming narratives in the work with clients with disabilities, and the grounding on narratives of full potential and client becoming their best selves. Further data collection posed questions to further clarify the connections between this tension and the development of competence to work with clients with disabilities. Potential questions clarified this dynamic by asking, "In terms of becoming vs. overcoming, how do you privilege one or the other? If you ground your interventions in 'becoming', how does this facilitates/hiders your work? If you ground your interventions in 'overcoming', how does this facilitates/hiders your work? Which one has helped you the most in developing competence and in what ways? Can you provide an example?"

In terms of igniting community, most of the participants acknowledged the powerful impact of their collaborative relationships, learning communities, and their connection with clients and their families. These sub-categories were described in the category **"it takes a village."** Further data collection clarified the specific processes and dimensions that informed the igniting or catalytic dynamics of community on the counselors' perceptions of their development of competence to work with clients with disabilities. Lynn, who acknowledged the powerful impact of engaging disabled communities and activists in institutional trainings as well as in collaboration to address client's issues, mentioned one example of this. Potential questions aimed

to clarify these dynamics could included, "What aspects of community stimulate and fuel your competence to work with clients with disabilities?"

In summary, further exploration around each of these process variables or precipitating factors was needed to clarify the underlying dynamics and refine the overall analysis. The next steps in this research process brought to light further refinement and confirmation of the emerging categories, dimensions, and process variables. The following interpretive dialogue interviews further clarified the preliminary analysis, and the second round of data collection and analysis assisted in deepening the understanding of these dynamics that led to the theorization of the development of counselor's competence to work with clients with disabilities.

Interpretive Dialogue Process

The next step in the collection of data was to conduct member checks in the form of interpretive dialogues with each participant. These interpretive dialogues helped me increase collaboration with participants and expanded the interpretive power of the analysis. During these interviews, each participant had the opportunity to adjust, expand, confirm, and disconfirm the preliminary analysis based on their experiences of the phenomenon (Clarke, 2005). Specifically, my intention around using interpretive dialogues had different objectives. First, interpretive dialogue interviews not only helped me expand the emerging analysis based on the participants' feedback, but they also fostered the relationships with my research participants to increase their level of trust and investment in the descriptions of their experiences. Second, this form of member checking helped me strengthen my research design by ensuring trustworthiness related to comfirmability.

As I prepared for the interpretive dialogue interviews, I constructed a document containing the emerging analysis with the categories that resulted from open and axial coding,

and which were already substantiated through grounding in the literature and peer debriefing with my research team. I sent this document in advance to my participants for their review prior to engaging in the interpretive dialogue interview. This emerging analysis document can be found in Appendix G.

As it is described in the following chapter, the interpretive dialogue interview questions were grounded on the participant's initial impressions and reactions to the emerging categories or themes identified in their process of developing competence to work with clients with disabilities. I actively posed questions aimed to generate individualized feedback for each category or theme within the emerging analysis and diligently worked to co-construct further descriptions that would expand, adjust, or confirm the preliminary results. Moreover, I emphasized the importance of identifying components that were missing or which would not fit their experiences of the phenomenon. In summary, all the benefits related to conducting interpretive dialogues added important value to this trustworthiness strategy that extended beyond member checking and fostered collaborative research engagement (Clarke, 2005; Hays & Singh, 2012).

Chapter V: First Interpretive Dialogue

Introduction

The interpretive dialogue interviews were conducted the week after the analysis of the first round of interviews was completed. As mentioned in the previous chapter, I prepared for the interpretive dialogue interviews by constructing and sending to my participants a document containing the emerging analysis with the categories that resulted from open and axial coding. Prior to the interpretive dialogues, the emerging analysis was already substantiated through grounding in counseling and disability studies literature and peer debriefing with my research team. From the total sample, twenty participants engaged in the interpretive dialogue interview. One participant did not respond to the researcher's efforts to engage her in the interpretive dialogue interview. All twenty participants acknowledged receiving the document and reviewing it in advance.

Specifically, this document contained excerpts that were provided by the participants during each interview and which were organized in a way that reflected the themes or categories and sub-themes or properties identified during the initial process of open and axial coding (See Appendix G). Each theme and sub-theme in the document was substantiated with the excerpts from different participants, which afforded each participant the possibility to see other participants' experiences with the phenomenon. Being exposed to other participants' excerpts also increased their ability to engage in further argumentation of their descriptions, therefore, increasing the significance of the emerging analysis.

I initiated each interpretive dialogue interview by highlighting the main categories that were identified in the overall analysis and asking the participants about their level of resonance with these emerging categories, dimensions, and properties. Once all participants acknowledged

their familiarity with these categories as a result of reading the document, all of them confirmed the overall resonance of this analysis with their experience of the phenomenon. Then, I transitioned to explain and amplify my emerging understanding of the categories, dimensions, and properties described in the document, as well as my preliminary graphical representations of the evolving concepts around participants' perceptions about the process of development of competence to work with clients with disabilities: **The Therapeutic Work**; **"It Takes a Village"**; **Evolving Compromises**; **Competence**; and, **Systemic Dimensions**.

During the interpretive dialogue interview, I diligently worked to position these findings as the result of my particular cultural and professional lenses, and encouraged the participants to challenge, expand, and refine these analytic categories, properties, and dimensions based on their understanding of the phenomenon grounded in their own positionality. With this, my hope was to name the space for a meaningful and shared construction and understanding of their descriptions. I continuously encouraged the participants to express their views around how my conceptualizations were fitting their experiences or not.

After the interpretive dialogue interviews were completed and transcribed, I proceeded to code these transcripts in order to capture, organize, and synthesize the reactions, confirmations, revisions, and amplifications of the emerging categories based on the participants' reflections. This process allowed me to further deepen my understanding of the emerging analysis and generate refined written and graphic explanations of the identified categories as they related to the process of development of counselors' competence to work with clients with disabilities. Please refer to Figure 10 for an updated representation of the emerging analysis. In the following section, I will work to provide a description of the participants' reactions, confirmation, revisions, and expansions of the emerging categories, which informs the overall process of

refinement of each category, process, and dimension so far identified. The following descriptions also include participants' excerpts from the interpretive dialogue interviews.

Interpretive Dialogue Analysis After First Round of Analysis

During the interpretive dialogue interviews, all participants confirmed how the emerging analysis resonated with their experiences of developing competence to work with clients with disabilities. Participants commented on the integrative nature of the analysis as well as the consistency in the approach across participants. The following descriptions demonstrate the participants' reactions and comments to the individual categories embedded in the emerging analysis.

The Therapeutic Work

Participants confirmed the category **The Therapeutic Work** as an important dimension in participants' perceptions of their development of competence to work with clients with disabilities. Moreover, they certified these categories' properties of ***disability as identity***, ***counseling relationship***, and ***tailoring the approach*** as critical components of their experience. Allison, Natalie and Maria shared their initial confirmatory reactions to the preliminary results and their resonance with other participants' experiences.

> ALLISON- I see that there are a lot of people who are in this profession who feel very much the same way as me. So, that was really cool to know that a lot of people in their programs feel like they don't really have a clear understanding of what disability is or how to work with disabilities, you know. I felt that, like, that's what I read.
>
> NATALIE- I think it's a really good breakdown […] I was reading other people's quotes, all of this stuff came up in everything I said.

MARIA- I was very intrigued by the entire document. I thought it was great to see the different viewpoints that everybody had.

Participants reflected on and confirmed the ambiguous and confusing construction of ***disability as an identity*** with unclear boundaries. Allison corroborated the tension in the definitions of disability as a mental health counselor as well as her personal struggles with the boundaries of disability categories related to mental health. Meanwhile, Peter expressed more clarity on these boundaries based on specific days of the year aimed to claim and celebrate disability as an identity.

ALLISON- I think I'm always going to go back to when I'm working with you is, disability. It's such a broad term and I think for me, the best understanding would be you telling me what disability means to you. And I think for me, that's funny because I think disability is going to mean something to everybody different. When you're strictly doing mental health treatment, your clients are saying to you, "I need you to fill out this disability paperwork." And I really struggle with this because again, is mental health issues a disability? Maybe in certain cases, but I struggle with them. I always feel like I'm going to struggle with that.

PETER- I thought it was interesting that most of the participants expressed confusion about the classification of disability as framed by identity, because we did a whole Disability Awareness Week event. April is Disability Awareness Month, and we did a whole thing on disability as a part of identity. Because people do identify, many times, it is part of their identity.

DDD further clarified these tensions and emphasized the need for the counseling profession to generate commitments around examining the boundaries of disability as a group

with whom counselors work. DDD's reflections highlighted the synergies between counseling and disability despite the overall silence of disability in the multicultural competence narrative that is mentioned later in the analysis. These linkages between counseling and ***disability as an identity*** were also confirmed by Henry, who corroborated the importance of seeing beyond the client's diagnostic categories in order to do meaningful work through the ***counseling relationship***.

> DDD- I guess it resonated with the fact of yeah, that is an issue. It becomes challenging when you're talking about, does this even person have a disability. If so, even just the, I guess universality of disability of I think we've all probably experienced some type of disability within our lives, but to what degree of severity depending on the definition. I think that's really important too especially in our field, because there's some people that define it and we bill on it from the medical model, and understand that through the ICD-10 or the DSM-V. That defines disability in a very specific way. It can definitely be confusing when you see a disability and you might have a hard time finding that definition within that model.
>
> HENRY- If we see the person as their diagnosis, it's not going to help, and it's not going to help the person if they refer to themselves as their diagnosis. It seems like steps you were talking about were transcending that.

Participants resonated with the importance of the ***counseling relationship*** as a fundamental aspect of the work with clients with disabilities. Sarah and Eliza's statements refer to the importance of the relationship with the client and its connection with other categories involved in the work with clients with disabilities. Brittney stressed the significance of emphatic

understanding within the counseling relationship with clients with disabilities and offered an

example of benefits of empathic peer relationships in her job place through peer specialists.

> SARAH- : Well for me, again just the first two themes where talking about the
>
> counseling relationship, that to me was a really big piece of when you and I spoke kind of
>
> what I thought needed to be addressed was that the therapeutic relationship and then
>
> again the fact that it does take a village.
>
> ELIZA- I think that that was very important to include, it's important to develop their
>
> relationship with the person, have a specific approach with working with the person.
>
> BRITTNEY- She was a vocational specialist, but she was a peer, and she would ... she
>
> just went the extra mile with everything. […] kind of like holding their hand through the
>
> whole process. But ... we felt like after a while clients didn't just to go to her for just
>
> vocational stuff. They would go to her and be like, "Oh the doctor just switched my
>
> medication. Have you ever been on it? What are the side effects? What do you think
>
> about?" She just became an expert resource for them for everything ... Relationships ...
>
> One thing that people always say when you have a mental illness or disability,
>
> relationships are hard, and she would be there with her door wide open ... And nothing
>
> was wrong for her ... And she really got that.

Participants also confirmed the need to ***tailor the approach*** when working with clients with

disabilities by meeting them where they are at in terms of needs and level of ability. Kara offered

an example about the need to be mindful of the client's functioning level to tailor an approach to

self-advocacy skills.

> KARA- I would say is just emphasizing more, because a lot of clinicians too, go by
>
> what's doable and then I'll hear clinicians say things like "Oh the client should fill out

those forms by themselves" but if you have a client with a learning disability or other

impairments it's not always the easiest for them to advocate or complete themselves.

Participants further dimensionalized the categories of **The Therapeutic Work** by naming

the variability in disability definitions for counselors as well as the multiplicity of factors to be

considered when tailoring the approach to address client's counseling goals. For instance, Lynn

highlighted one factor that dimensionalized the analysis related to tailoring the approach.

Specifically, Lynn amplified the need for a shared agreement around issues of consent for

counseling treatment and engagement in sexual behaviors by adult clients with developmental

disabilities.

> LYNN- The idea of consent when working with adults with developmental and
>
> intellectual disabilities, and how to determine someone's ability to provide consent. Some
>
> of the ... when it comes to consent for treatment, or when they're living in a therapeutic
>
> community and it comes to sexual consent. Those are things that I definitely ... even
>
> though I had some training in my Masters program, those were not topics that we really
>
> thoroughly covered, and I don't really think that there is a lot, or definitely not sufficient
>
> information out there about the aspects of all of that.

In summary, the participants confirmed how **The Therapeutic Work** evolved for

counselors as they clarified *disability as an identity*, grounded their role in the *counseling*

relationship, and further *tailored the approach* in the work with clients with disabilities.

Therefore, once entering the counseling relationship with clients with disabilities, it became clear

the counselor's intentionality on assessing or clarifying questions around the impact of disability

in the client's life and its relation to the presenting problem. While this process remained

grounded in the counseling relationship, the counselors worked to tailor the approach to better

meet clients' needs. The next category that emerged in the discussion of the counseling work related to the surrounding community, collaboration, and support.

"It Takes a Village"

Participants strongly resonated with the category **"It Takes a Village"** when developing competence to work with clients with disabilities, and participants consistently confirmed its related properties *collaborative relationships*, *learning communities*, and *clients and families narratives*. Participants overall commented on the importance of collaborative and supportive work as counselors who serve individuals with disabilities. Faith highlighted the collective involvement of supportive networks and a sense of togetherness as a counseling community in the service to clients with disabilities.

> FAITH- Just the fact of how many people you need to have involved and to work together. You can't just put it on one area. You really have to all work together for this person. They need a lot of support with the disabilities and stuff like that. Kind of keeping that in mind that it's not on you to do by yourself and we can't expect somebody else to do it all by themselves. We all have to work together.

Furthermore, participants consistently confirmed the relevance of *collaborative relationships* when describing their perceptions of their development of competence to work with clients with disabilities. These collaborations became apparent through supervision, consultation with other counselors and mental health professionals, as well as through the involvement with the clients' community and disability rights movement, eventually leading counselors to form their close communities of support or *circle of trust*. Below are some excerpts that showcase the confirmation of this analytic property.

LYNN- I definitely, after we spoke the last time, I was thinking more about it, and actually since you and I have spoken, through some of my work stuff I've been doing some different things with the Office of Disability Services here and the disability rights community. That theme just kind of kept popping up in my mind of really there needing to be this really ... I don't know, holistic approach to anybody gaining the skills or awareness or the knowledge that they need to work with the disability community.

REECE- I think I mentioned to you last time, I'm on a team so it's not just me working with a particular individual so I try not to be that official because it's not just me coming up with all the ideas. If I don't really understand how to do something I can bounce an idea off of one of my teammates. Everyone on my team has different experience levels so that makes it helpful too. Somebody might know something that you don't or be more familiar in a certain area if you're not. In addition to my co-workers, I also have my supervisor and my program manager who works very intensely with us and sits at our meetings every week. Actually, we just had a meeting yesterday. We talk a lot about our different clients and different issues that people are experiencing and what to do. To answer your question more directly, I feel like I do get a lot of support from my co-workers and that's what helps me a lot of the time.

ALLISON- No, I think that it's so important to have collateral with people because, people might not present the same way with you as they do with somebody else, so that's always important. Obviously someone has a medical disability being able to contact their primary care physician or whoever is in charge of that, so you guys are all on the same page, so it makes complete sense to me. You know, with my new work that I'm doing now, I have to work with schools, I have to work with, you know, if they're involved in a

community activity I could get in contact with them. So, it's important to have everybody's opinion so that you can have a clear understanding of the client and their needs.

Furthermore, throughout the interpretive dialogue interviews, participants confirmed the importance of engaging in continuous education through *learning communities*. Maria highlighted the need for counselors to engage in continuing education to obtain current information and better serve their clients. Participants mostly referred to learning communities in terms of seminars, workshops, and continuing education units, and they directly linked these learning opportunities with the development of proficiency in specific issues. Maria also challenged the notion of **expertise** in the work as a counselor.

MARIA- I think the biggest part is the continuing education and learning more about how we view our clients. […] because culturally we may not know how it's appropriate how to refer to a client. We think we know how to interact, but sometimes those are things we have to learn as we go along because every culture can be a little bit different. I think it's the continuing education and that everything is changing in the world. […] We're considered experts compared to our clients, but there's always new literature coming out and new research being done, that type of thing [that we need to know]. We actually had that conversation about how we may be labeled as an expert, but are we really?

Participants corroborated the need to include *clients and families narratives* to inform the work of the counselor. Participants highlighted the criticality of extending the counseling approach beyond the counseling room to reach clients' families and their overall communities. Queen and Cortina showcase the confirmation of this category's property.

QUEEN- I think that piece about client in the family's narratives was pretty critical. I guess I was just thinking as counselors we really kind of ... we take those things for granted and think that we believe we all do those things. At the end of the day when you reflect back on a session, you reflect back on the client in their greater context, are we doing a good enough job with that?

CORTINA- I like the client and family narratives because it felt empowering for the population, working with people with disabilities […] I liked it because it gives that sense of support and moves it beyond the therapeutic environment, like a one-on-one work. To really extend to include the community, the family, because I think, with people with disabilities that it really is more ... It takes a less individualistic approach and especially with people with disabilities they often live in their families still. They often stay very connected because they can have the support.

Participants further dimensionalized the category **"It Takes a Village"** by elucidating the contrasting ends of the continuum on which the village can fall. It emerged during the interpretive dialogues that the community can be or be facilitative when working together to meet the needs of clients with disabilities. Therefore, the village could optimize counselors' perceptions of their development of competence in the work with clients with disabilities by being supportive, resourceful and supportive of the client's needs, but it could also be not accessible to some counselors or further hinder the collaborative work by perpetuating barriers and problematic narratives of disabled clients that directly affect the counselors' perceptions of their development of competence to serve these communities. Gloria commented on the difficulties in the access to the village as a professional counselor in private practice, whereas DDD highlighted that the village can also be negative and perpetuate the problem.

GLORIA- You know it's funny because I think because I'm in private practice; I'm not

working in the context of a system [agency]. A little bit for me is different. I get to define

it and interpret in a way that makes it more centric to my practice and how I treat people.

I don't necessarily have access to that village because of the confines of my practice. So I

do think that that is something that I miss and would like to have access to in a way and

it's not as readily available because of the confines of private practice.

DDD- [in a Netflix Movie about pederasts within the Catholic Church] They used the

phrase, it takes a village not only to solve problems, but it takes a village to let problems

continue. That was one of the themes of the movie was that if it takes a village of people

to overcome abuse, it takes a village of people to allow abuse to continue. That's what

they ultimately were trying to show in the movie is we're not going to go after the

individual priests, because they'll just get shuffled to a different place or whatever else.

We're going to go after the whole system because it doesn't just take one priest. It takes

the person that just shuffled them, it takes the whole Catholic Church. It takes the whole

village to keep this going. If it takes a whole village to help resolve [the environmental

barriers experienced by people with] disabilities, it takes a whole village to continue

perpetrating the barriers that create the disability in and of itself too.

In summary, the participants confirmed the community-grounded and collaborative

nature of the counseling work with clients with disabilities through the category **"It Takes a**

Village." The relationship between this category's properties became further elucidated and led

to the merging of the property *circle of trust* into *collaborative relationships*, as well as

expertise into *learning communities*. Specifically, participants identified the materialization of

close networks of support, or circle of trust, as naturally evolving in their collaborative

relationships with supervisors, other mental health professionals, and peers. Also, participants confirmed the emergence of expertise or proficiency on specific issues as they engaged in learning communities that enriched their knowledge base. Therefore, the participants confirmed the importance of community grounding reflected in these three domains: ***collaborative relationships***, ***learning community***, and ***client and families narratives***, for the development of their perceptions of competence to occur. See Figure 9 for a representation of these three properties as they relate to the category "It takes a Village." The third category discussed with the participants during the interpretive dialogue interviews was **Evolving Compromises**. In this category, the participants also confirmed its resonance with their perceptions of competence to work with clients with disabilities.
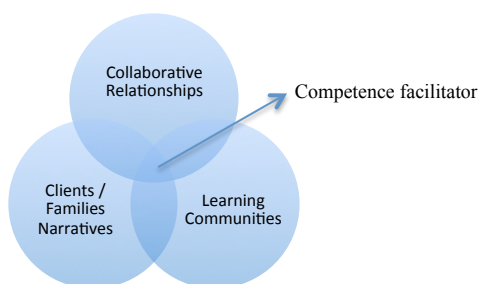
Figure 9. It Takes a Village's Dominant Domains of Influence

Evolving Compromises

Participants overall confirmed the category of **Evolving Compromises** and reflected on their own process of building consciousness, achieving sense of purpose, overall respect and appreciation for clients with disabilities. Henry expressed the level of resonance between this category and his developmental process as a counselor. Henry further confirmed the importance of ***time*** and ***exposure/experience*** for this development to occur.

HENRY- I couldn't help but picture myself during that process, how my initial responses have eventually changed. It did change with more experience and also having more education with that. What I thought was great is how you summed it up. All those words never directly came out of my mouth, but wow, that's a great description of me.

Moreover, participants confirmed the initiation of the evolution in their compromises by holding ***negative attitudes*** towards the counseling work with clients with disabilities. Cortina described these ***negative attitudes*** as pity and sadness, and confirmed them as the initial stage in the evolution of the compromises. Cortina also acknowledged to be still in the process of moving beyond these attitudes when working with her clients with disabilities.

CORTINA- ... At least from my experience, it was my brother example, got diagnosed with Multiple Sclerosis and had a walking disability now. I'm not sure yet if I'm at a sense of purpose with it, more so it's part of the evolving process. I think for me right now, in this stage of development it shifted my thinking to want to learn more, to want to understand it more. To find a place where I don't pity them or feel sad for them. To find a place where I don't look at my brother as just someone ... I don't look at him as a disability. I think that's a process thing, how I'm evolving, I think there's a consciousness piece, working through my negative attitudes, and that eventually gets you a sense of purpose.

Some participants further dimensionalized the property of ***negative attitudes*** by generating an argument embedded in "not knowing what to do with the client" as a factor influencing the counseling focus. Thus, when counselors are experiencing these negative attitudes and do not know what to do in the session, they might resort to compartmentalizing and shifting their focus of attention exclusively on the disability or on the mental health symptoms of

the client. Faith and Allison showcased the lack of confidence and competence associated to the shifting focus in the work with clients with disabilities.

FAITH- They come in and go, "I don't even know where to start. I don't know exactly what I'm doing", and kind of trying to build that confidence that you do feel comfortable. I think once you get going and once you really start working with them on the disabilities, you start to realize that the whole focus on the disability disappears. You're not thinking about them as having a disability. That kind of blends into the background and you're really focused on just, "What do you need to do to help this client? but I think it takes time to get to that point. I think it's just yourself just kind of realizing that this is what I need to focus on and that this other stuff isn't as big of a deal as I'm making it out to be.

ALLISON- And I think that's what's really difficult for beginning therapists is, you know, when you are a substance abuse counselor, you're thinking, "Oh, I'm only supposed to work with them on their addiction." And you know that that's not the case, but only at the beginning that's what you feel, you know. So, you don't really ask questions about their mental health because your main role is their substance abuse. Just like when you're working with disabilities, let's say developmental disabilities, your main focus is developmental disabilities. It's not necessarily maybe their underlying anxiety or depression. I think for us it's just being more open to whatever it is that I'm working with just meeting them where they are at.

Lynn further linked this shifting focus to the process variable ***becoming vs. overcoming*** described in the following analytic category. Specifically, beginning counselors might experience the need to help client overcome their disability by assessing, clarifying, and

understanding the medical details of their disabling conditions. As a result, when realizing their inability to make disability (medical) determinations, counselors at early stages of development might altogether shift the focus and feel that their role relates exclusively to emotional support.

> LYNN- One thing I was thinking when I was reading that category, I think that something that counselors, in general, in my experience, are intimidated by, especially beginning practitioners, is what exactly a counselors role is when it comes to assessment. Counselors, a lot of times, at least emerging counselors, think of their role in assessing as being this formalized thing, and they understand that they don't have the training or the qualifications to make a disability determination. […] Not having any of that knowledge ... I guess maybe it's not even that they didn't know how to get it, but I think they felt that they shouldn't get it because their role is to be an emotional support.

In terms of *self-initiated learning*, the participants confirmed the importance of initiating contact with the client's community that extends beyond the counseling room, the importance for self-initiated learning through trainings and actualized information, as well as the value of taking additional steps to reach and collaborate with other professionals. Gloria exemplified the additional efforts needed to connect with other professionals involved in the work with their clients when practicing in private settings.

> GLORIA- It's really an effort to get others to form collaborative relationships with psychiatrists and other people in the field. It requires a lot more effort. It definitely requires seeking it out and becoming a part of a greater system.

In terms of *sense of purpose*, all participants corroborated the importance of personal work aimed to embracing personal and professional struggles, facing assumptions, recognizing privilege, and disrupting the discomfort and avoidance that might emerge from biases held by the

counselor. All participants confirmed the need for *reflexivity* for the counselor to become aware

and conscious about these personal reactions. For instance, Natalie and Jerome confirmed that

personal work leads to the cultivation of consciousness around personal reactions and

professional role in the work with clients with disabilities.

> NATALIE- I was like, "Yes," and I was thinking that people need to recognize their
>
> privilege, in so many areas but specifically in this area.
>
> JEROME- There's a piece of becoming a therapist, becoming a counselor that ... in the
>
> first part having a certain amount of awareness about yourself is important. I understand
>
> being able to reflect on self and understanding self and acknowledging yourself when
>
> you're having struggles. I get that. Things like being honest like okay, I really don't want
>
> to work with this person. I'm acknowledging I don't want to work with this person. That's
>
> important. But I think it's deeper than that too in the sense of how does a therapist
>
> understand that they don't want to work with a person? Yes. I thought that that part was
>
> really good because I think there's a piece of okay, [counselor] Level one is I don't want
>
> to work with this client. Level two is, I don't want to work with this client, I know I don't
>
> want to work with this client. Level three is, I don't want to work with this client, I know
>
> I don't want to work with this client and I'm aware of why I don't want to work with this
>
> client. It's also creating that consciousness or I don't ... I know why I don't want to work
>
> with this client. That's the piece that is so important.

Furthermore, participants confirmed personal experiences with disability as a process

organizer in their perceptions of development of competence to work with clients with

disabilities. For instance, Kara explained how having personal experiences with disability

increased her ability to understand her clients, and Lynn explained the familiarity with disability

since her childhood as facilitative factors for the work with clients with disabilities. Also, Brittney asserted that not having personal experiences with disability might challenge the ability to have a full understanding of her clients who experienced disabling conditions.

> KARA- I also could identify that ... I was somebody, I think I told you during my interview early on, that was drawn to people with disabilities, like the kids with autism and working with those populations but I can also agree that, as my personal life changed a little bit, like my future brother-in-law, he has bipolar disorder and then seeing it more from a personal end also did influence the way that I treat my patients, like maybe a bit more patience and understanding.

> LYNN- I think that having that personal experience, or having some early experiences ... I was thinking, after we spoke the last time, that there were a number of people that were in my family's life: friends of my parents and their children that have various intellectual and developmental disabilities when we were kids ... growing up as a kid and those other kids just being my peer group, they were just the other people that I played with. That definitely gave me a different kind of exposure that I think probably impacts my openness or my fear. When I was reading through that section of your themes and the different comments that people mention, I definitely heard a lot of fear, and so I think that any familiarity or personal experiences can help to really reduce that fear. So, I think that some of those things are not ... not that a person can't gain competence and can't gain comfort in all of those things, but I definitely think that the point where people start out changes what their experience will be.

> BRITTNEY- And he said to me, "Do you have any idea what it's like to have to take medication every single day in order to just stay out of the hospital?" And I was stunned.

And I thought to myself, "Oh my God, I don't!" I don't, I have no idea what it's like to

have to take medication every day, just to get through the day. And I haven't been in a

psych ward in a hospital. And I was like, "Wow!"

Moreover, Unice spoke to how the achievement of the sense of purpose as a professional

counselor has an impact that goes beyond the counselor and extends to the community where

people know each other. Unice mentioned small communities such as the disabled community or

the Hispanic Community where hope can be transmitted among clients, given that they can see

other clients feeling better.

UNICE- I believe in what I do. I believe in the modality of treatment that I provide

because I have seen it work with individuals with disabilities and I share that with my

clients so they can see others' progress. It is an investment we make together and in

completing it, they experience positive benefits that have lifelong effect.

One participant further dimensionalized the category of **Evolving Compromises** by

highlighting the ethical commitment for client care, which informs the counselors' process of

disrupting *negative attitudes*, fostering *self-initiation*, and promoting the achievement of the

sense of purpose. As a researcher informed by the values of the counseling profession and my

own ethical commitments, I deemed DDD's comments highly important and decided to highlight

ethics as an area of questioning in further interactions with the participants. Specifically, DDD

mentioned that as she has transitioned her evolving compromises as a professional counselor, the

dimension of ethics has become more prominent as a helpful resource to delimitate the

boundaries and responsibilities of her professional role.

DDD- In one sense I would love to tailor my practice to certain types of clients, but

there's a reason that there's an ethical component that cautions people of doing that. If we

all hand-pick our specialties, then there's inevitable going to be certain populations that are left out, which then perpetuates that problem that these marginalized groups are experiencing. If our purpose is to remove that barrier and remove that marginalization, then I need to remove my own negative attitudes, whether it's my own biases as an ethical component, my own competencies as an ethical component, or even just I think it's the ethical thing. It outlines that first contact if someone becomes my client. If that first contact is what somebody that for instance has a very severe intellectual disability, and maybe can't benefit from traditional CBT, that doesn't mean they're not my client and that's it. I still have to figure out how to engage, and what interventions to use to get them connected to the services that they need.

Furthermore, two participants amplified the property of *sense of purpose*, and paired it with the strengthening of counseling professional identity and the presence of love in the work as a counselor. Specifically, Sarah spoke to how gaining competence and becoming more confident and intentional in the role of a counselor, and specifically in the work with clients with disabilities, increased the sense of professional identity as well. Lynn commented on the process of becoming and achieving sense of purpose as being intimately related to the development of empathy and love for the work with these clients.

SARAH- Well I think that as you gain competence, your ability to kind of go with the flow so to speak and learn to kind of roll with being more person-centered which is I think a really important aspect of working with people who have disabilities is recognizing that their disability is one aspect of their identity, but it's just one. There's many different kind of layers to the onion, just like it is for us as counselors. It's very much like onions. Who we start out as when we're in our master's program is not who we

evolve to be and even over the last two or three years I can say that I have evolved and changed and kind of morphed into a different type of therapist. I think that working with someone who has disabilities gives you a little bit more perspective on your own identity as a professional.

LYNN- I mean, I feel like it's definitely tucked into the categories in your narrative, but ... whenever I'm reading research that talks about the process of becoming or what it takes to get to a certain part of your work, I just think that, for me, a big part of it is always love. I just think that that's so foundational, that empathy, and that ... even beyond empathy, just this ... I don't know, love I guess. Not because somebody has limitations, but just that desire to really connect. Yeah. I don't know. That feels ... Even as I was reading, that was the feeling that I was having as I was reading some of the categories, and so when I saw your last picture and you had those two little stars at the bottom, I was like "I would just like to see a little heart at the bottom, too."

In summary, the participants confirmed the category **Evolving Compromises** and its properties *negative attitudes*, *self-initiation*, and *sense of purpose* along with the process variables *reflexivity*, *time* and *development* through *exposure and experience*. Counselors expressed high resonance with the description of the transition from earlier stages that were highly influenced by biases and personal reactions. According to the participants' confirmations, beginning counselors tend to experience increased negative reactions to the counseling work with the population with disabilities, which further inform their lack of interest, training, exposure, confidence, and competence. However, as counselors transition their lived experiences, become older, and engage in reflexivity, their ability for empathy and commitment tends to increase, facilitating their self-initiative to learn about and be exposed to this population.

Furthermore, this reflexivity is further galvanized through the counselors' exposure to personal experiences with disability. The resulting effects of this exposure tend to align with the acknowledgment of assumptions, privilege, and the disruption of initial negative attitudes and avoidance of this population through personal work. Finally, the conjunction of these factors seems to lead to a heightened sense of professional purpose, which seems to be experienced by the participants as the intentional and celebratory commitment to the professional role of a helper grounded on genuine care, hope, and respect for the client. The fourth category discussed with the participants during the interpretive dialogue interviews was **Competence**. In this category, the participants also confirmed its resonance with their experience with the phenomenon.

Competence

Participants confirmed the importance of all four components of **Competence:** *disability as a cultural group*, *consciousness*, *interrelated work*, and *dimensions of oppression*. Unice named the direct influence of competence on the quality of the counseling relationship and the ability to feel empathy and respect for the client's needs. Unice also mentioned the detrimental impact of lack of competence when working with clients with disabilities.

> UNICE- I think competence is very important because in order to for us to be empathic, we have to have some level of competency and it translates into the relationship that we build with our clients. If we don't have that level of competency, we are going to face some conflicts, some struggles with our clientele, which might be easily translated. Although, we might not want to admit to it, but I think that if we don't pay attention to it, we can fall easily into a pattern of just isolating ourselves and becoming very stagnant in the therapeutic work set that we provide.

Participants confirmed the importance of recognizing ***disability as a cultural identity*** in the process of developing competence to work with clients with disabilities. Reece commented on the relevance of acknowledging and taking into account the client's cultural background and the social ramifications of disability in its interactions with the environment. DDD emphasized the need to take into account the presence and interactions among subcultures within the disabled community as well as the client's identification or not as part of these cultural groups. Also, Jerome further highlighted the complexities of disability as an identity that intersects with other identities and provided an example of disability's intersection with class in the work as a professional counselor.

> REECE- I think it's important to hit on it [counseling intervention] from different angles culturally. That's all very important and sometimes it's things we don't always pay attention to on a daily basis. Sometimes we're very concerned with treating ... What's the diagnosis, what are the treatments that would relate to that? We don't always pay attention to a person's disability background and I think that it's important to highlight that.

> DDD- I think that's important too because if you think about just competence, I'm going to use the deaf culture because I think that's a pretty well-known obvious one. That doesn't mean that if somebody comes and that is deaf, that I automatically assume that, "Oh, they belong to a culture that values their disability." That doesn't necessarily mean that that certain individual use it that way.

> JEROME- Then you have somebody else with the same diagnosis but they don't have all the supports. Not that they didn't try but because things didn't go well because of their legal status or their attorney wasn't as good as the other person's attorney. It could be as

simple as that. In the line of work that I do for [name of agency], we ... you may have one person who meets with ... who has the services because they were in the right place at the right time. You have another person could really benefit from the services but can't get them because they're on a six month waiting list for a diagnosis or the services aren't available now. That could be anything. I think at the end of the day it all comes back to how much money's available for the services for folks. If you take a look at housing for people with disabilities or Medicaid Service Coordinators, there's just no ... If the money's not there they're not going to get it. There's a waiting list for Section 8 housing. There is a waiting list to get psychological evaluations. If you have the money you can probably get a psychological evaluation tomorrow. If you have the money, you don't have to wait for Section 8 housing. I think that's another piece of it is that you could have two exact folks but there's no uniformity.

Participants confirmed the relevance of ***consciousness*** as a property of the category **Competence**. Participants directly linked and merged the property of consciousness to the need for reflexivity and personal work illuminated in the third category, **Evolving Compromises**. Furthermore, participants corroborated the significance of ***interrelated work*** through connection to the village in their perceived development of competence to work with clients with disabilities. Natalie offered an example of the importance of collaborative relations with other organizations that might assist the clients in achieving goals related to their presenting problem.

NATALIE- In congruence with the previous theme of 'It Takes a Village', which also mentioned the importance of interrelated work, that's so important because I've been trying to do that within [place of employment] but also outside of [place of employment], so like outside organizations, getting things involved, like even today I started looking up

tutoring centers. I looked at some tutoring links that are paid, they charge. I wanted to see ... I emailed it to the disability counselors and asked them to add to it, and maybe we can all make up a document for students with learning disabilities so they can access ... Because sometimes this tutoring on campus isn't enough for them. I asked them also to contact Access-VR and see if they can find any cheaper, sliding scale, or free services for students that may not even be registered with Access-VR.

Understanding the ***dimensions of oppression*** that surround disability was a crucial aspect of developing competence to work with clients with disabilities. Participants highlighted the need to recognize oppression and acknowledge this as something overtly present in the lives of disabled clients. Natalie extended these ***dimensions of oppression*** to other identities, such as the Queer community, and emphasized on the need to recognize oppression as currently impacting clients who have marginalized identities in order to develop competence to work with clients with disabilities. Moreover, Unice proposed the linkage between the ***dimensions of oppression*** and ***reflexivity*** as a necessary step to recognize counselors' role as part of the system that perpetuates indignities clients with disabilities often experience in clinical and medical practice. Natalie stressed the need to enact the ethical and multicultural commitments that would guarantee being alert and aware of these risks in order to develop competence to work with clients with disabilities.

UNICE- Sometimes, again, there's a lot of stigma out there. There is a lot of people having this level of understanding that individuals with disabilities can't function or can't be effective or can't make changes, and I think that's false. That is so false. If we are competent and if we work with these individuals and have patience, it might take a little bit longer than what other individuals might go through, but I think it's tangible and it's

reachable, and I think that's what we want to translate to our clients because they've already faced so many more obstacles than we can imagine. I don't want them coming into this environment to have to face more obstacles. I need to be very aware and be very confident so that I can develop whatever it is or whatever skills need to be developed in a way that they can utilize it.

NATALIE- We don't really necessarily look at the oppression area there, not just the history of it, but the current oppression; because everyone's like, "Oh, once the ADA Act or whatever came out, everything's fine." Just like in the Queer community, everyone's like, "Gay marriage is legal so everything is fine." I'm like, "No, there's still systems of oppression," and you caught that well in the analysis.

In general, participants confirmed the process variable ***becoming vs. overcoming*** as it relates to the **Competence** to work with clients with disabilities. Queen associated this variable with the tension between the medical model and the social model of disability and confirmed the resonance of becoming with the nature of the counseling work. On the other hand, Gloria provided an example to describe the difficulties in balancing the focus on becoming one's best self and the pressure to overcome aspects of their health to regain functionality, while working on becoming their best selves.

QUEEN- This overcoming piece sounds so much like pulling yourself up by your bootstraps and kind of that idealization that it seems ... I interpret it, honestly, as kind of inappropriate. I think it's so prevalent in our society to think like that but we have a responsibility, whether it's just through supervision, or whatever it is, to challenge some of those biases, I believe. I think it's a concept that seems to fit. For me, [the counseling work] it's knowing and accepting where you're at and moving through, recirculating

through a process, I think, for people. They get a little bit better, they might go back

through a process of grief. Or whatever it happens to be for them.

GLORIA- Sometimes we look at something as overcoming it, are we negating it, are we

just pushing somebody to a place that is different without looking at the experience that

they're having of becoming that or just you know what becomes somebody's identity and

how you help them through that. You're helping somebody to accept their identity and we

have some real work sometimes, you know, what has to come first. I've just worked with

somebody now who's struggling with obesity. Can we call that a handicapping condition?

And as far as I'm concerned in her case it really is. You know, she can't get around even

she's so obese at this point. And how you look at that in that light now of helping her

accepting herself but on the other hand she has to overcome it.

Lynn further dimensionalized the property ***becoming vs. overcoming*** by highlighting the

potentially positive nature of overcoming difficulties in the counseling work. Per her report, the

counseling work can be aimed at overcoming traumatic experiences that further debilitate the

clients who have been victimized because of being disabled or it can also represent potential

routes for self-empowerment and self-advocacy, while overcoming the impact of trauma. The

following example, provided by Lynn, illuminates the dimensions of this process detaching it

from exclusively overcoming the disability and achieving normative functioning.

LYNN- I think I saw that as a little star, becoming versus overcoming. I think that that

definitely spans from talking about persons with disabilities through, then, persons with

chronic mental illness, and exactly what you're saying, that tension between maximizing

and accepting, in a very empowering way, what are the things that they have to live with,

and then also pushing up against those growing edges in the places where they feel like

they can overcome. I think that that's definitely something ... most of the clients that I've worked with who have had disabilities, I've been working with them in a trauma context, and so the focus on our work has been on helping them to manage, and in some ways overcome, this traumatic experience or the series of traumas, which of course always intersects with their disability status.

In summary, the participants confirmed the category **Competence** and its properties *disability as a cultural group*, *consciousness*, *interrelated work*, and *dimensions of oppression* along with the process variable *becoming vs. overcoming*. The participants corroborated the need to recognize disability as a diverse cultural group with intragroup dynamics that usually result from the intersection with other identities. The awareness about these dynamics and intersections also relate to counselors' consciousness, which is cultivated through ongoing reflexivity and commitment to reach out to other professionals for supervision and consultation. The participants positioned the cultivation of consciousness as a necessary condition for their perceived development of competence to work with clients with disabilities.

Additionally, the participants confirmed the need for recognizing and disrupting the dimensions of oppression that surround disability, which are currently and consistently impacting the lives of disabled clients. The participants further extended the commitment to reflexivity while balancing the tension between expecting clients to become or overcome their issues. The fifth category discussed with the participants during the interpretive dialogue interviews was **Systemic Dimensions**. The participants also confirmed the resonance of this last category with their experience of developing competence to work with clients with disabilities.

Systemic dimensions

Participants acknowledged that all four properties of *double bind*, *silence of disability*, *productivity in mental health systems*, and *prejudice and stigma* were **Systemic Dimensions** impacting their perceptions of development of competence to work with clients with disabilities. In general, participants confirmed the presence of a **double bind** system that further disempowers clients with disabilities by meeting less than basic social and emotional needs while taking away clients' initiative. Natalie, DDD, and Iris illustrated their agreement with this property, and Henry expressed his views of this property as a "double-edged sword" impacting the lives of disabled clients.

> NATALIE- the system of continual care undermines their ability to become well in certain areas, and then because, one, that they just give continuous services, and then they take away your services if you get better, so say you get enough better in one area, all your services are going to go away. Even though you might need seven other services or two other services, but if you're good in one, they take everything away from you. I think that that keeps the patients sick in a lot of ways.
>
> DDD- There's certainly a double-bind that exists. […] I certainly have seen a lot of instances where on one hand you might be over functioning and you're patronizing a client, and at the same time, how much can you expect somebody to do something for themselves, especially if they have seen this pattern so much so that it's normalized for them. It can be difficult to challenge a client to be proactive and self-advocate, especially when the system hasn't always caught up yet. You're actually instead then asking a client to do something that may not be attainable goal, which then perpetuates the whole problem, and it's the recipe for depression. I can see that double bind very much so.

IRIS- Again, when I was thinking of years ago, giant mental institutions where people were even neglected, abused. And then I can think of more residence, residential treatment in which I worked in situations where people have greatly helped and where people have indeed been abused and taken advantage of.

HENRY- That double-edged sword, how the system on one hand is designed to help, but it's also a deterrent because it's so difficult to navigate.

All participants recognized the ***silence of disability*** as something impacting their overall training and the opportunities for further professional development in their professional practice. Participants highlighted the lack of preparation around disability issues, the lack of representation of disability as an identity in the training curriculum, as well as the lack of trainings focused on disability issues offered by employers. Lynn highlighted the systemic silencing of disability that leads to lack of access and clear procedures and protocols related to disability, (i.e., consent).

KARA- I think what you mentioned about the professors not being as aware and it lacking in our professional treatment is also huge in regards to the teachers feeling competent teaching it. I saw that as something really important in the analysis and then also, again, lack of access to workshops and continuing education.

PETER- I mean, it's a very small percentage of a diversity class that focuses on disability, and it's very, very understated. There's not a lot there.

REECE- I did see that some people [other participants] acknowledged education. They said that there were classes on, I guess, education in that area, but not so much how to actually work with people with disabilities, which I agree.

LYNN- I definitely think systemically, that's true. I think, you know, when we think about a lot of the ways that agencies are set up, that they're not always designed from the beginning for persons with disabilities on any level. I mean, I think about agencies where I've worked, where there's needed to be modifications on a physical level, but also when we look at the ways paperwork is handled, consent, all of those kinds of things.

The participants also recognized and confirmed the impact of the demands for ***productivity in mental health systems*** as a property influencing their perceptions of the development of competence to work with clients with disabilities. Kara and Henry corroborated the high demands for productivity by being assigned big caseloads. These productivity demands seem to increase time commitment and reduce the opportunities for connecting with the overall community of mental health professionals as well as the opportunities to seek out further training.

KARA- With our caseloads being so big I think that the more clients that you take that are special populations with, not necessarily one disability, but when you have multiple disabilities for one patient. […] And it's so time-consuming like I find myself there after work filling out those forms and then having to chase down the doctor to sign them. […] That's not really reflected on my caseload, all this extra work that I'm getting or putting into it- So I think you kind of brushed on that but I just think that that's important too, that the more disabilities that a client presents with, the more time management they need and that that's not really balanced well within the agencies when it comes to our units of service and meeting our quotas and whatnot.

HENRY- There's so much pressure on us to see as many people as possible, and what sucks is sometimes we may not have as much time to devote to each patient about that.

Also, when that happens, we don't have enough time to devote for our ongoing education

and self-evaluation, and also […] So that is definitely tough, too. I do agree that overlap

is there.

Finally, the participants corroborated ***prejudice and stigma*** as factors impacting their

perceived development of competence to work with clients with disabilities. The participants

linked this property to ***dimensions of oppression***. Reece reflected on the stigma and systemic

oppression, and emphasized the need for counselors to gain awareness about prejudice and

stigma that surround disability as an identity in order to increase their level of competence.

REECE- Sometimes we don't always understand the background of certain disabilities

and there could be a lot of, like you said, oppression and stigma. I had a client talk to me

the other day about stigma and sometimes it's easy for us to say, "Oh, just take the [name

of bus] bus or just take…" [Name of bus] is actually a bus out here that transports people

who have disabilities that have to apply for it. He always has an issue ... I should say they

have an issue with it, "What if people see me on it?" Or, "How can I take somebody on a

date and then tell them that this is what I have to do?" That's just one example out of a

thousand examples that you can probably come up with.

Some participants further dimensionalized the category of systemic factors. Brittney

commented on the variety of opportunities for clients with disabilities depending on geographical

context. Brittney described working with people who came from extremely disinvested contexts

that further limited the possibilities for wellness and resiliency of clients with disabilities. Also,

Tela expressed contrasting views in which clients with disabilities might feel that counseling

services are not for them, given the presence of stigmatizing views of their lives and their needs.

Yet, she also stated that clients with disabilities are high users of mental health services, which

contradicts the idea that clients with disabilities might avoid services if they do not feel as welcome and embraced by the mental health system.

> BRITTNEY- I had a couple of clients ... actually I had a client who was from Florida who actually moved to New York because he found out the mental health services were better. I had a client from Haiti who came here because in Haiti there were no mental health services. I think it really depends on where you're from. There are many places within the US that don't provide the best mental health services.

> TELA- Yeah, I guess, I haven't personally had the experience where people with disability, I find that to be high utilizer of counseling service versus them feeling like it's not a service that is helpful for them. Or something that is not theirs. And so for me that was a little- I'm sure other people might have different- or other people have different experiences. I just, I've seen kind of ... people with disabilities, that are, there's very high-very much high utilizers of mental health services.

Furthermore, Natalie added an additional dimension to the property of double bind by positioning the counselor in a critical place for client advocacy. For one part, this participant acknowledged the responsibility to follow systemic policies and procedures in the work with clients with disabilities. Moreover, given the position of power that counselors occupy in the system, this participant highlighted the possibilities for advocacy and to become allies from the position of insiders of the mental health system. This dimensionalization of the counselor role within the system not only offers an additional perspective of the counselor presence in the system, but it also affords countless opportunities for counselors to disrupt oppressive dynamics that further disempower clients. Therefore, this dimensionalization opens a window of

opportunity for advocacy in the work with clients with disabilities if counselors are able to strategically navigate the system and serve as potential allies.

> NATALIE- I'm even thinking about with my own patients, when I write up my patient whatever, the report that I send to Disability Services, I make them sound so much worse than they are. I'm like, "They can't even look at a bus, they need like a private..." whatever, you know. Yeah. they get services cut, so even if they can fix some things ... like some of my patients have fixed some things, but I don't tell the whole story to the system. It's sad that it has to be that way, because we can become allies, we can become advocates, and I feel that I am both at this point for the community, the population, the persons with disabilities; but aside from being ... I can advocate, advocate, advocate, but if the system is structured in such a way, you can advocate until you're blue in the face, they're going to still take away services. That's when you have to start lying or embellishing, right?

In summary, all the participants confirmed the category of **Systemic Dimensions** as well as its properties of ***double bind***, ***silence of disability***, ***productivity in mental health systems***, and ***prejudice and stigma***. The participants corroborated the resonance of the impact of these systemic issues in their perceived development of competence to work with clients with disabilities. Participants acknowledged the presence of a systemic double bind that seeks to meet the clients' needs but further disempowers them. Also, the participants recognized the generalized and systemic silence of disability as an identity consistently represented in training curriculum or in professional development opportunities. Moreover, the participants highlighted their resonance with the demands for increased productivity by the mental health system, which significantly decrease the opportunities for further counselor outreach and professional

development. Finally, the participants recognized the impact of ongoing prejudice and stigma that influence the lives of disabled clients as well as counselors' possibilities for their perceived development of competence. All participants stressed the importance for counselor reflexivity and intentionality around disrupting these oppressive dynamics.

Emergent Grounded Theory Integration

My analysis emerging from the initial interviews provided a significant amount of information that I then thematically organized into categories and properties. Moreover, as I was identifying and documenting these categories and their properties, I became increasingly aware of the possibilities for merging and collapsing, as well as further expanding and dimensionalizing what was present throughout the analysis. Thus, the initial process of identifying and describing the categories and underlying dynamics that inform the counselors' perceptions of their development of competence to work with clients with disabilities was highly disorganized, overlapping and reciprocal.

Through the interpretive dialogue interviews, I intentionally generated the opportunity for the participants to respond and con-construct the proposed categories and properties. I diligently worked in generating this opportunity by presenting the emerging results to the participants as a work in progress and as a partial understanding of their experience from my own positionality. In this way, I conveyed respect and collaborative engagement for the co-construction of the analysis. In this next section, I discuss how the identified categories and properties overlap and come together to explain the counselors' perceptions of their development of competence to work with clients with disabilities. This description captures the analysis in the first round of interviews and the first interpretive dialogue.

During the interpretive dialogue interviews, the participants commented on their overall level of resonance with the emerging categories and properties. Some participants described their own process of reflection after engaging in the first interview, specifically in relation to their level of competence and generalized work with clients with disabilities. As they advanced in their reflexive process, they were able to name other examples and reflect on a variety of dimensions for the categories initially described. Along these reflections, for Queen, it also generated a sense of increased professional responsibility, commitment to becoming competent, and disappointment for the lack of training in disability issues. Her excerpt showcases this process of reflection.

> QUEEN- I think one of the things that, after we talked, that kind of sat with me for, at least the rest of the day and maybe even perhaps a couple of days, was this piece around managing my professional responsibility to learn more and to develop more in this area. Then also my frustration as a practitioner that there's not more required, I think, in our training programs. I think there's a piece of me that I feel like I'm a little torn between this part of accepting and knowing that I need to take more professional responsibility for this. At the same time feeling [that] I don't have more of an infrastructure to support me doing that.

During the interpretive dialogue interviews, many participants emphasized the intertwined nature of these categories, and conveyed appreciation for the graphic representation offered. In the excerpts below, Faith's excerpt demonstrates the view of the analysis as being intertwined.

> FAITH- I think the way that you broke it down really was good. I mean, I don't think there's any way not to have a little bit of overlap, just because of what you were working

with, it is going to overlap naturally, but I think the way that you conceptualized it and broke it down into each one of those themes was really, really good. To me, it's interesting to see, again, what you're taking, how you took all the information you got from people and how you've interpreted it and put it out, I think that was great. I think you're right on with what you're doing.

At the completion of the first round of interviews and interpretive dialogue interviews, along with the coding and analysis of the participant's descriptions and confirmations, a grounded theory started to emerge. Figure 10 illustrates the emergent grounded theory integration related to the counselors' perceptions of their development of competence to work with clients with disabilities. This visual representation demonstrates the expansion and collapsing of categories based on the participants' feedback and their answers to questions that emerged from the initial analysis. Even though in this figure I attempt to organize the emerging information to potentiate its interpretive power, I firmly detach from linear or organized claims of the counselor's development. Thus, the elements of this graph are used to illustrate potential directionality between the analytic factors described by the participants.
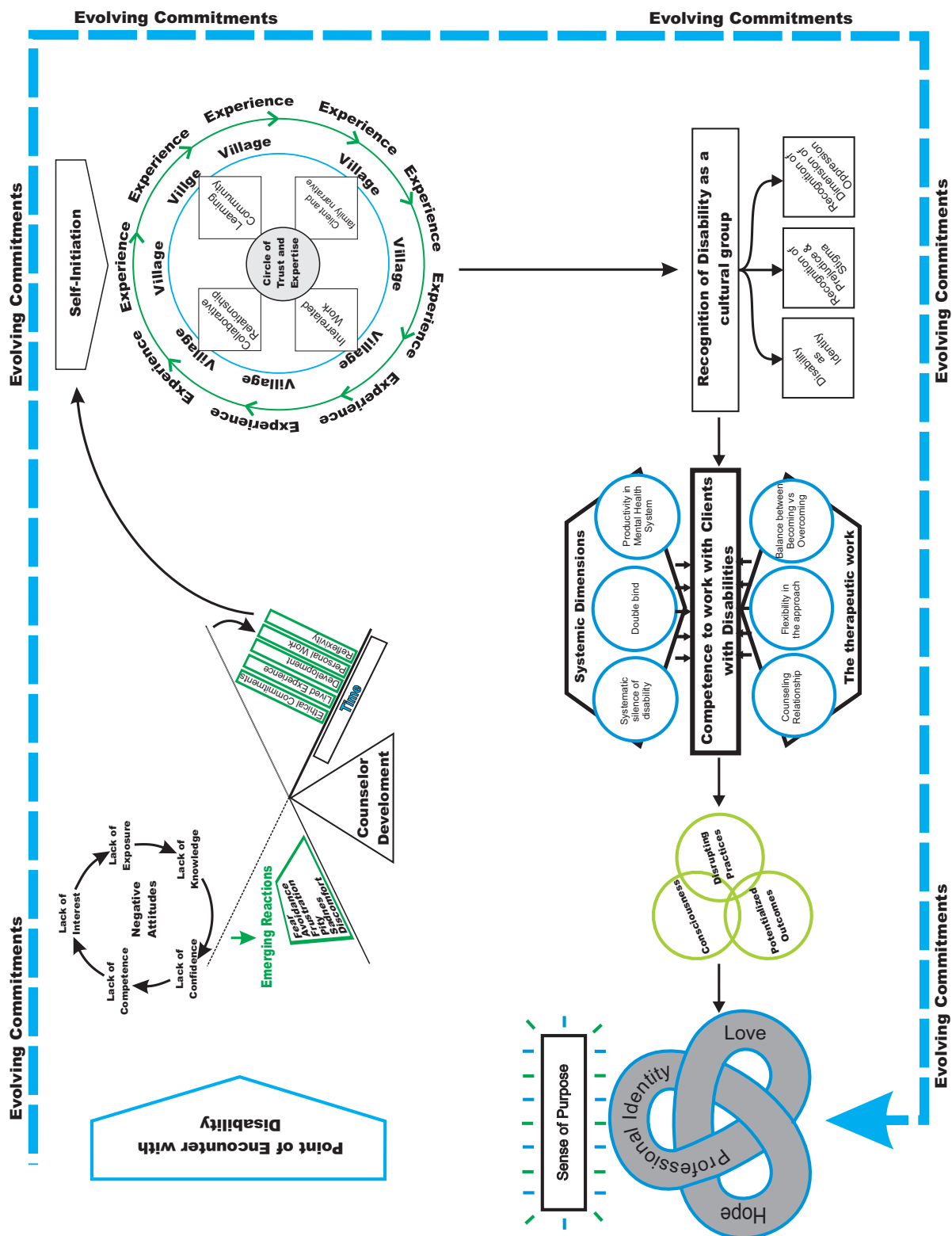
Figure 10. Emergent Grounded Theory Integration

The categories **The Therapeutic Work**, **"It Takes a Village," Evolving Compromises**, **Competence**, and **Systemic Dimensions** are displayed throughout the diagram in order to illustrate the intertwined influences involving the participants' perceptions about development of competence to work with clients with disabilities. The layout of these categories, properties, and dimensions aim to represent the emergent interpretive dynamics that have been identified so far in the counselors' perceived development of competence to work with clients with disabilities. The initial step in this process corresponds to a primary point of encounter with clients with disabilities as licensed professional counselors. Even though the majority of the participants associated this initial point to clinical courses in their training (i.e. practicum, internship), many of them emphasized these initial moments as licensed professional counselors who either work in institutional settings or in their private practice.

This point of encounter with disability was usually related to ***negative attitudes*** that involved the realization of the lack of interest in serving this group, lack of training in disability matters, lack of exposure during professional practice, lack of confidence to engage these clients, and ultimately, diminished competence to work with this population. These attitudes were linked to significant reactions of fear, pity, sadness, frustration, discomfort, powerlessness, and avoidance to working with this population. These reactions varied depending on type of disability and were usually lessened when the client was verbal and able to engage in verbal interaction. The development of counselors was further mediated by process variables of ethical commitments, lived experience (***growth and aging***, personal experiences with disability), personal work, and ***reflexivity***. These process variables helped counselors, over ***time***, to transform their initial attitudes and reactions to people with disabilities. Therefore, counselors'

development became a dynamic and fluid process of negotiating and resolving the impact of initial biases in order to enact a professional disposition of openness to ***self-initiated learning***.

The process of enacting self-initiative for counselors was strongly related to being able to connect with their professional communities and opportunities for ***experience and exposure***. Through the category **"It Takes a Village,"** the participants illustrated the beneficial nature of professional partnerships with clinical supervisors, peers, and other mental health professionals across ***collaborative relationships***. The nature of these interchanges facilitated an ***interrelated work*** with their professional and ***learning communities*** that further enhanced counselors' knowledge base and resourcefulness to individualize the approach to their clients. Furthermore, as counselors consistently engaged in these partnerships and learned from professional and learning communities, they eventually developed close networks of professional and personal support, or ***circles of trust***, in their clinical work. Throughout this process, counselors also nurtured their self-initiated learning by connecting with their ***clients and families narratives***, which led them to further inquire in cultural issues pertaining to their client's life circumstances.

As counselors engaged at the broader community level and gained more knowledge and understanding of their client's needs, they experienced a variety of realizations related to the recognition of ***disability as a cultural group***. The counselors who were more attentive to their clients' narratives and histories of disenfranchisement, and those who were the most reflective about their own personal experiences with disability reached realizations that helped them recognize ***disability as an identity*** with its historical dimensions of disenfranchisement, marginalization, and resistance. Counselors became aware of the multilayered ***dimensions of oppression*** that this population has historically encountered, based on problematic assumptions of capability, worth, and citizenship, as well as the social movements aimed to counteract this

impact. In this process, counselors recognized that these dimensions of oppression have further led to the perpetuation of ***prejudice and stigma*** in all aspects of the social fabric. Moreover, the recognition of the dimensions of oppression in this cultural group also overlapped with other grounds of identity, such as LGBTQ identity, immigration status, and social class.

As counselors became more aware of the social realities of their clients and further engaged in their professional and learning communities, their **Competence** to work with clients with disabilities started to emerge. This competence was reflected in counselors' **Therapeutic Work** through a variety of factors. The counselors experienced the ability to ground their professional role in the ***counseling relationship***. Counselors described the counseling relationship as the ability to form a therapeutic alliance with the clients that conveyed authenticity, unconditional positive regard, and empathy. The therapeutic work was also reflected in the counselors' commitment to remain flexible and creative when ***tailoring the approach*** to meet the individualized needs of their clients with disabilities. Moreover, in tailoring the approach, counselors became aware of the tension between helping the client become one's best self and clinical and societal expectations of overcoming one's disability to regain functionality. The property ***becoming vs. overcoming*** was considered by the counselors as a developmental task that informed the view of their work as well as the ways in which they tailored their approach to work with clients with disabilities.

Participants' perceptions of their competence to work with clients with disabilities was also impacted by **Systemic Dimensions** that further informed the counselors' possibilities for the engagement with their learning communities. When unresolved, these systemic dimensions contributed to counselors' bias and informed the ways in which they individualized their approach to work with clients with disabilities. One of the systemic dimensions impacting the

counselors' perceived development of competence was the institutional and systematic ***silence of disability*** across curriculum and learning domains. As the main expression of this silence, many participants reported the absence of professional trainings focused on disability. Moreover, the silence of disability also extended to the institutional dispositions for access and inclusion of disabled clients.

Another dimension impacting counselors' perception of their development of competence was the ***double bind*** represented by a system that embraces disabled clients to meet their needs, but that becomes inaccessible when clients try to take initiative to change their social circumstances. Counselors expressed the many difficulties they experienced in learning and navigating these dynamics in order to advocate for their clients' needs given the contradicting positions in which they found themselves. For instance, one participant commented on her clients striving for wellness, while having to remain sick enough to be able to keep government benefits. As a researcher informed by disability studies, I considered this participant's comment to be significantly illustrative of the double bind disabled clients face. I deemed this comment to disrupting to the seemingly congruency expressed by all other participants regarding disability as an identity within a medicalized system, and the work of counselors aimed at wellness and optimal development.

A final systemic dimension impacting the counselors' perceived development of competence was the increased demands for ***productivity in mental health systems***. Participants faced increased expectations for productivity, including large big caseloads, increased pressure to achieve measurable outcomes, a lack of recognition of the time invested in reaching out to their learning communities, and the need to adapt counseling materials for specific populations (i.e., translating handouts). When counselors did not fully engage in reflexivity about their work,

about the power represented in the counseling room, and the often detrimental impact of these systemic dynamics on their clients' lives, they inadvertently aligned with problematic narratives that perpetuated medicalized ideas of charity, loss, adjustment, and pathology as the core of their therapeutic work.

The emergence of competence to work with clients with disabilities was reflected in three domains (See Figure 11). The overlapping expression of these domains informed the counselors' therapeutic work, their navigation of systemic issues impacting their professional practice and the lives of their clients, as well as the counselors' disposition for further learning and integral development.
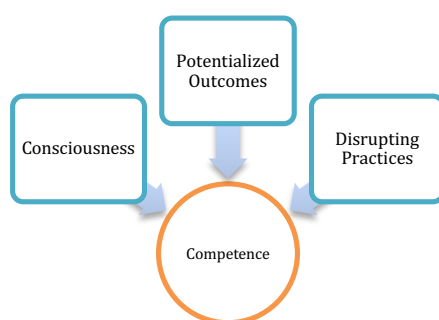
Figure 11. Domains that Reflect the Enactment of Competence.

Counselors enacted ***consciousness*** by actively implementing in their therapeutic work the recognition of systemic, socio-political, and policy aspects impacting the lives of their clients and highlighting the importance for social movements striving for equality within the disabled community. Furthermore, counselors reached higher levels of consciousness about disability as they actively engaged in self-reflective practices aimed at deconstructing and acknowledging their power and able-bodied privilege. Counselors also strived for consciousness by unpacking the effects of representing a medicalized system that further perpetuates the continuation of services grounded in pathologizing views of the clients' lives.

Another domain in the enactment of competence was the presence of potentialized outcomes. Counselors referred to evidence-based practices in the work with clients, but more importantly, to the ability of building meaningful relationships with clients that represented alliance, support, and hope. As part of the outcomes that fully demonstrate clients' individual and community potential, counselors further reflected on issues of helping clients overcome traumatic experiences, regain self-initiative to create personal change, express self-advocacy, and bridge the various communities where they operate (i.e., mental health services, disabled community, school, family). Also, counselors enacted competence by using their positionality within the system to further disrupt practices that take away clients' initiative for wellness and personal development. The counselors embraced the role of an ally and advocate when navigating systems and also worked to disrupt dynamics that prevented the clients' overall engagement with the mental health system.

The participants' perception of their overall development of competence to work with clients with disabilities is illustrated in Figure 10. The process represented in this graphic was reflective of counselors' perceptions of their **Evolving Compromises** that were conducive to personal and professional ***sense of purpose*** through clinical practice. In this sense, Evolving Compromises became a central category that framed a variety of experiences and held all analytic pieces together at the same time. Counselors experienced sense of purpose as licensed professional counselors by highlighting their capacity for the instillation of hope, genuine and loving care, as well as heightened professional identity that differentiated them from other mental health professionals when working with clients with disabilities. Thus, the sense of purpose in Figure 10 is represented by the interrelated and endless articulation of hope, love, and professional identity, and is only a part of the continual process of professional development that

consistently links counselors to points of encounter with individuals from marginalized communities.

At the end of the first round of analysis that included the first interview and interpretive dialogue interview, an emergent grounded theory was identified to describe the participants' experiences in developing competence to work with clients with disabilities. Figure 10 illustrated the categories and properties that explained the underlying dynamics related to the participants' perceptions of their development of competence. The subsequent round of analysis, which included a second interview and a second interpretive dialogue, provided further clarification, refinement, and confirmation of the emergent grounded theory as it related to counselors' perceptions of their competence to work with clients with disabilities.

Conclusion

The first round of interviews and their analysis led to the identification of initial categories and processes involved in the counselors' perception of their development of competence to work with clients with disabilities. The subsequent interpretive dialogue interviews allowed for the participant's expansion, adjustment, confirmation, and dimensionalization of the emerging categories, properties, and graphic descriptions developed from the initial interviews and analysis. The participants as a group confirmed the categories and properties initially identified and offered meaningful expansions and dimensionalizations to the proposed concepts and processes. After reviewing each of the categories with the participants during the interpretive dialogue interviews, I encouraged them to think about how these emerging concepts matched their experiences of developing competence to work with clients with disabilities. Moreover, after presenting the Figure 7 where all categories and their dimensions are depicted, the participants initiated the conversations around collapsing,

synthesizing, and linking some of the concepts while expanding and further dimensionalizing others. The resulting synergies between categories identified by the participants led me to co-construct a refined graphic representation of their experience. See Figure 10 for an integrative representation of the refined categories emerging from the interpretive dialogue interviews.

As my participants engaged in the interpretive dialogue interviews, I posed open ended questions about their perceptions of the analysis as well as their level of resonance with the emerging categories about properties and their experience of developing competence to work with clients with disabilities. After obtaining and discussing their initial reaction to the analysis, I worked to develop deeper and further areas of exploration that pertained to each category and property. Participants actively engaged in confirming and expanding on each of the categories and proposing additional layers of interpretation of certain categories. For instance, the category Evolving Compromises was further dimensionalized by adding the influence of ethical commitments and professional identity being reflected in the counselors' professional sense of purpose. As a researcher strongly informed by the ethical commitments of the counselor role, I considered highly important to integrate more information about ethics in further interactions with the participants. In order to obtain more information about this, I followed up with questions such as, "In what ways ethics play a role in the evolutions of your negative attitudes?" and "how do you make sense of the transition towards a professional sense of purpose that also leads to professional identity?"

As mentioned in Chapter IV, the interpretive dialogue sessions not only helped me expand the emerging analysis based on the participants' feedback, but also assisted in fostering the relationships with my research participants to increase their level of trust and investment in the descriptions of their experiences. This form of member check helped me strengthen my

research design by ensuring trustworthiness related to comfirmability. In short, interpretive dialogues helped me increase the collaboration with my participants and expand the interpretive power of the emerging analysis related their experiences of developing competence to work with clients with disabilities.

The subsequent second round of interviews was aimed to further integrate and clarify the identified expansions and dimensionalizations proposed by the participants during the interpretive dialogue interviews. Thus, the second round of interviews included questions related to the role of ethics in the development of competence to work with clients with disabilities, the counselors' interactions with the client's community, the counselors' realization and use of their power and privilege within the mental health system, as well as their navigation of the counseling focus to meet becoming versus overcoming narratives. Please see Appendix H for a list of specific questions used in the second round of interviews.

Chapter VI: Second Round Analysis

Introduction

This chapter presents the emerging analysis from the second round of interviews. This emerging analysis comprises the identification of four additional analytic factors that expand and dimensionalize the emergent grounded theory of counselors' perceptions of their development of competence to work with clients with disabilities (see Figure 16). Specifically, the subsequent second round of interviews was aimed to further integrate and clarify concepts and dimensions proposed by the participants during the interpretive dialogue interviews. The second round of interviews included questions related to the role of ethics in the work with clients with disabilities (i.e., what is the specific role of ethics in shaping your experiences of development of competence to work with clients with disabilities?), and the counselors' interactions with the client's community (i.e., what aspects of the client's community stimulate or fuel your competence to work with clients with disabilities?). The second round of interviews also posed questions related to the counselors' realization and use of their power and privilege within the mental health system (i.e., how do you see your power and privilege influencing your ability to work with clients with disabilities?), as well as their focus in their counseling role regarding becoming versus overcoming narratives (i.e., how do you navigate the becoming and overcoming dynamics in the session in order to reflect client's progress in treatment?). Please see Appendix H for a list of specific questions used in the second round of interviews.

During the second round of interviews, participants provided descriptions and examples of specific aspects within the process of developing competence to work with clients with disabilities. These additional analytic factors propose internal linkages and reciprocity among the previously established themes. Therefore, in this chapter, the reader will find the organized

descriptions of these additional analytic factors that strengthen the internal consistency of the emerging grounded theory.

Additionally, as the participants engaged in the research process while consistently maintaining their clinical practice as licensed professional counselors of clients with disabilities, counselors' additional descriptions are reflective of their intellectual engagement and applicability to clinical work. For instance, the participants described how engaging in the research process and holding conversations about disability with the researcher have significantly increased their awareness of the variety of factors involved in their growth related to their competence to work with clients with disabilities. Conversely, their engagement in the research process also influenced their intentionality in the enactment of the counselor role when working with disabled clients (i.e., advocating for client's access to care). These brief reflexive pieces demonstrate the potential of initiating conversations around disability and the beneficial nature of counselors' growth in serving clients with disabilities. Moreover, in alignment to my commitment for reflexivity as a researcher, and in collaboration with my research team, several considerations have been defined and are presented in the following section.

Contextualization of Researcher's Reflexivity

As mentioned in Chapter III, it was my intention to remain grounded in the commitment for reflexivity as a researcher and critically articulate my meaning making of the emerging analysis during peer debriefing in collaboration with my research team. In honoring this commitment, I remained continuously immersed in the data collection and analysis and maintained journal and memo documentation to be further used in the peer debriefing sessions. Through this process, I became aware of the dissimilar descriptions of participants and my own

interpretation of analytic factors related to the counseling focus as well as the divergent semantic interpretations of the word "compromises" within the research team.

Specifically, as the participants described their intentions to help the client overcome the barriers represented by their disability and regain wellbeing, I found myself experiencing a strong personal connection to the dichotomous and problematic narratives of normality that have significantly and historically affected the disabled community. These personal connections also connect to my simultaneous training in the discipline of Disability Studies, which equips me with additional frameworks that have emerged as a form of resistance to these narratives from the disabled community. This process of gaining awareness facilitated my ability to prevent assumptions about counselors' intentionality. Staying open to the participants defining their own intentionality better prepared me to take a new opportunity, through the second round of interviews, to further explore, deepen, and better understand the navigation of the counseling focus within their therapeutic approach. Additionally, this heightened awareness further facilitated the possibility to resonate with my participants' experiences as a clinical mental health counselor myself, and reminded me of the importance of remaining grounded in the commitment to understand their insights and experiences as they live them.

Additionally, given my Spanish-informed linguistic and cultural configurations, when crafting the representation of themes in the analysis, I proposed the category "Evolving Compromises" to illustrate the counselors' ongoing process of developing multilayered commitments to their professional role and the population of clients with disabilities. In one of our peer debriefing sessions, a conversation about cultural meanings of the word "compromises" afforded us, as a research team, the possibility to arrive to a term that is more congruent with the intended meaning I was initially proposing. Therefore, the category of "Evolving Compromises"

was renamed "Evolving Commitments." "Evolving commitments" was used in the context of this research to represent the grounding values and principles that guide counselors' clinical practice and evolve over time and experience. This change was reflected in the emerging grounded theory in Figure 16 and introduced to the participants during the second interpretive dialogue interviews.

Thus, a fundamental aspect of this awareness building process as a researcher was my ability to consistently collaborate, confirm, contrast, and debrief with my research team. This process of peer debriefing with my advisor, Dr. Nicole R. Hill, significantly amplified the trustworthiness of the results that compose the emerging analysis. The resulting consensual definition and establishment of categories in the analysis facilitated the co-creation of a robust emerging grounded theory about counselors' perception of their development of competence to work with clients with disabilities. The next section highlights the additional analytic factors within the emerging analysis and provides a framework for their articulation within the overall emerging grounded theory.

Second Round of Interviews and Emerging Analysis: Additional Analytic Factors

The analysis for the second round of interviews entailed the reading and coding of each participant's transcript. The analysis of these transcripts was conducted through open and axial coding of the participants' raw descriptions of the phenomenon (Corbin & Strauss, 2015; Hays & Singh, 2012). Moreover, as these codes were organized into analytic factors, some relationships between them and the overall analysis were established. During the second round of interviews, four emergent analytic factors were identified: **Ethical Decision Making**, **Client's Community**, **Understanding and Using Privilege**, and **Counseling Focus**. Following is a detailed

description of these analytic factors and their properties with participant narratives to substantiate the emergent findings.

Ethical Decision Making

Ethical decision making informed the ways in which counselors made service decisions and developed competence to work with clients with disabilities. When opening the conversation around ethics in the work with clients with disabilities, participants named issues of confidentiality, boundaries, and sexual consent as particularly relevant. In terms of confidentiality, Allison and Gloria emphasized the importance of interacting with consent in a way that protects the client but also honors the client's right for privacy. For instance, Allison mentioned the importance of determining consent from the client to contact other mental health professionals and enhance client conceptualization.

ALLISON - So like the standard is making sure we have consent to speak to [clients'] other doctors. Because individuals with disabilities typically have other challenges which require specialists to come in and look over them. So I would want to have a collaborative conversation with those individuals to find out what they are treating. What's the diagnosis and what's the prognosis. So that way it can help me conceptualize and work with the client.

GLORIA - I do believe that ethics guides you totally in terms of how you treat people and your treatment. I guess for me ethics and confidentiality, things like that come up a lot when I work with couples and I see one separate from the other ones or when I see teenagers and their parents. The ethical issues around what you tell parents when you're working with teenagers. They think that's where the disability piece comes in too because where as if I'm working with a 17 who's typical I might be much more respectful of

confidentiality. Versus when I'm working with a 17 year old who is A-typical such as now my patient who has Asperger's and she'll say things that I know I need to say to the parent and talk to the parents about because of her developmental level. I have to look at the differently. I think that's where the ethics and the disability piece overlap.

In this excerpt, Gloria highlights the overlap of ethics and disability but does not offer a deeper understanding of the cultural implications and power asymmetries of clinical decisions. The participants also described their connection between ethics and boundaries in the work with clients with disabilities. Specifically, Maria commented on the importance of keeping professional boundaries even when clearly embodying her disability identity as a person who has a chronic illness condition that can debilitate her. Jerome and Henry described the importance of keeping professional boundaries when being available to his students in order to avoid misunderstandings and prevent counselor burn out.

> MARIA - When I think of ethics I usually go towards boundaries, because that was always an area that I was weaker in and still work on every day. Because, when you're talking about things like, chronic illnesses, you tend to, give a little bit more of your personal background at times, to empathize. So, the ethics to me is important because it sort of reigns me back in to remind me that, there are not details, not all details that they need to share. That type of thing, so that's where I always go with the boundaries because I've had clients, when I've been out sic, that are worried about me. And, I have to remind them, I'm fine, I appreciate that you are concerned, but I'll be okay. That type of thing. But, I also think that's, part of that, is you have a bond with your client. But there is that fine line with ethics, I think. And, it's hard at times. But, ethics

JEROME - I think for myself, because I generally am fairly thoughtful and empathetic about people, and I think about what people need already, I also think about, ethically, when I think "ethics," I think a lot about boundaries, and I think about how we provide services to folks in a way that meets them where they're at, but also sets clear boundaries.

HENRY - So, there is like some aspects of counseling, which should be counterintuitive, and some of those aspects are discussed within the ethics of difficult practices, especially boundary setting. And by maintaining those boundaries, it helps to prevent burnout, and also just being aware of what the limitations of the counselor.

Iris further dimensionalized the discussion pertaining to ethical domains involved in the work with clients with disabilities. This participant named the tensions between autonomy and sexual consent of clients and the counselor's ethical navigation of these decisions when the client has a disability. Ultimately, Iris stressed the importance of practicing within the boundaries of ethical commitment for human dignity.

IRIS - The first thing that pops in my mind is making, is taking, our clients human rights into consideration around whether it is medication or mental health treatment or the right to make their decision in their life around sexual ... You know around their sexual life, that kind of thing. You know, consent for or being able to give consent and what kind of ... So and I used to deal with that when I worked down State, pretty heavily. There would be a Human Rights Committee and you know there were assessments to determine if someone is able to give consent for certain things.

However, the participants' narratives reflected a robust emerging process of decision-making that seemed to take place when encountering a client with a disability, and which includes the domains of **boundaries of competence**, **cultivation of awareness**, **self-initiation**,

availability of village resources, and *recommendation for services*. Figure 12 illustrates the emerging process that is informed by counselors' ethical commitments and that delineate their treatment decisions in their work with clients with disabilities.
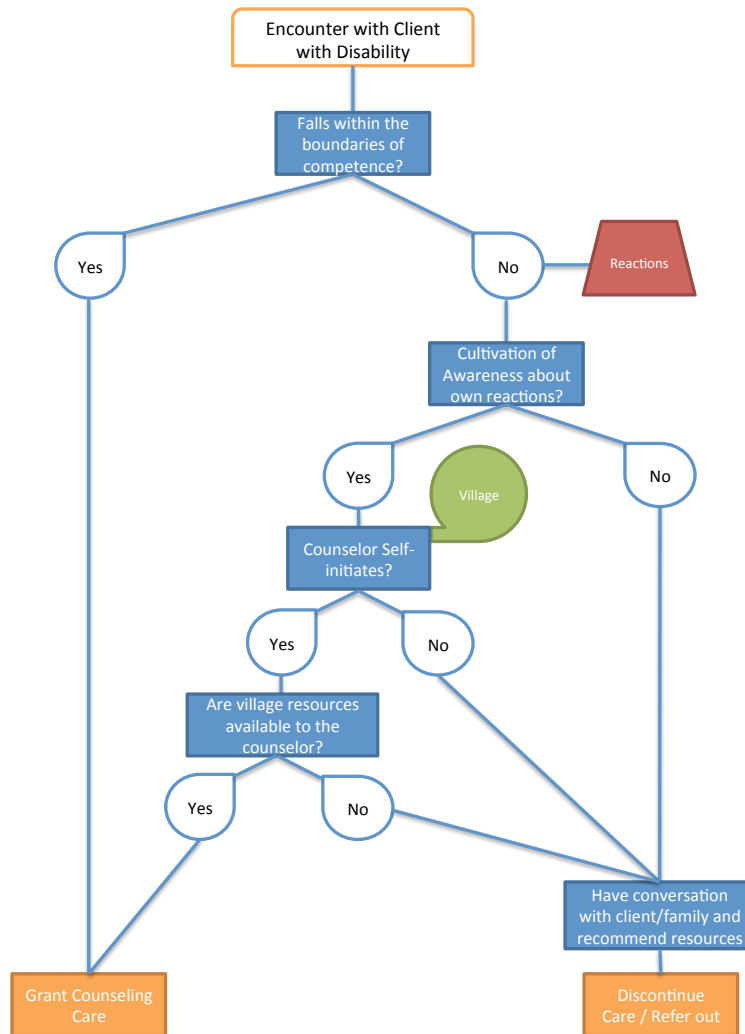
Figure 12. Ethical Decision Making

This analytic factor is represented by a sequence of decisions that the participants make when encountering a client with a disability in their clinical practice. The first step in this process pertains to the domain of **boundaries of competence**. Thus, when participants encounter a client with a disability, the first decision step in this process relates to ACA's Code of Ethics

responsibility to operate within the boundaries of competence (*falls within the boundaries of competence?*). Iris, Jerome, and Allison commented on the need to define these boundaries as the step prior to engaging the client in counseling services, and ultimately make decisions to guarantee the best client care.

> IRIS - I think its perfectly okay for a professional to say I have never had experience and this makes me uncomfortable ... I mean, that's a journey, that's a professional clinical journey right. Does that sound goofy? So, I mean I jumped in to it pretty early on working with people with disabilities but I think it is all right for someone to realize their own limitations or their own strengths. And to say, you know what, I don't think that I could treat this person. Maybe there is someone else who is better suited for this.
>
> JEROME - I think in a general sense, when you say that you don't want to work with a group of people, that is an issue with the therapist. I think if there is a client that you don't feel competent about, and think it's a better idea if they would go somewhere else because you don't feel competent about, then I don't necessarily think that is an ethical problem. I think that is actually probably doing what is a better fit.
>
> ALLISON - So like for example Multiple Scoliosis or Cystic Fibrosis, to throw out words I don't even know what they mean but I know that theses are medical disorders that people experience that would cause them to be quote unquote "disabled" and might impact them. I don't really know too much about this stuff. So either I would have to, on my downtime, learn more to feel more competent enough to understand and help them. Or refer them out because I don't feel like I am adequate enough to handle these problems.

When the question about competence was answered positively, it led them to engage in the provision of counseling services for clients with disabilities while grounded in a robust base of knowledge, awareness, and skills. When the question about competence was answered negatively, it not only led the participants to experience negative reactions (fear, frustration, pity, avoidance), but it also led to the question related to the participants' willingness to respond to the ethical commitment for the **cultivation of awareness** about these reactions (*cultivation of awareness about own reactions?*). When participants did not honor the commitment for the cultivation of awareness, it led to the discontinuation of care and referring out of disabled clients. For instance, Maria, Allison, and Faith stressed the need to acknowledge and "own" the reasons behind the decision to not work with a specific group and cultivate awareness about the impact of their own reactions on treatment decisions.

MARIA - But, I think, if you're really uncomfortable with a client, you need to own that and make a decision. Either do research and learn more about it or, if it's something you truly can't handle, then you need to talk to a supervisor.

ALLISON - The first thing is that if you find yourself constantly referring yourself out with disabilities you need to seek supervision as soon as possible. Because you need to be able to say to yourself 'Hey why is this a certain population that I keep referring out.' That is not ethical either. You know you clearly have a bias and you need, and as a therapist personally I believe that you should be able to work with an array of populations and if you find yourself singling out somebody you need to seek supervision and process why does that keep happening.

FAITH - I think, you know, to say that I'm not going to work with a certain population, you know, I have to look at really what is my reason behind it. Am I truly not trained to

be able to work with that population? Or is it just my comfort level? You know, and that's the way I would have to look at it. If I'm not really, really trained for that population then ethically I think that it's better that I not. If it's a comfort level thing, I think that's when I really have to look at it.

When this question about whether awareness was being cultivated was answered positively, it led the participants to demonstrate *self-initiation* by finding answers through the engagement in supervision, learning, and peer consultation in their professional community. Participants widely made reference to the support received from supervisors and their learning communities for training and further education. For instance, Peter explained the step of problem solving after realizing one's reactions, whereas Sarah emphasized the need for research and professional consultation in the work as counselors.

> PETER - I think, maybe, it's also an ethical thing now that we're talking about this. I can either say, "Well, that's not my job. I'm going to refer you to, whatever." If a student has already made the therapeutic connection, has built rapport with me then I feel an ethical responsibility many times to follow through, it is my job to help them get the services that they need, rather than referring them out.

> SARAH - I think that ethically when we're faced with a client that we don't feel we're competent in, I think it's our ethical duty to challenge ourselves and to consult and seek further guidance, whether it's via research that we're doing or consulting with another professional in the field. I think it's an ethical dilemma that most of us face not just in the disability world, but just in general as counselors.

Participants were able to demonstrate self-initiation as long as the ***availability of village resources*** was accessible (*are village resources available to the counselor?*). When these

resources were available to counselors, it further led to the engagement of clients in counseling services. However, when these resources were not available to the participants, it led to client referral. Kara commented on how beneficial her supervisor support has been in her perceived development of competence, whereas Reece described her difficulties to reach the extended professional community given the boundaries of her private practice.

> KARA - I feel like [I have a] good background. Or I always feel like pretty competent. But certain issues where I've also been blessed really good supervisors so far in this point in my career.

> REECE - I think especially, 'cause I used to working and I know a lot of individuals, you know, have private practice and a lot of the times they are separated from other colleagues but you know, being in an agency I have the opportunity to be around people constantly and bounce ideas and everyone has different levels of expertise.

When participants did not honor the commitment for the cultivation of awareness or when they lacked the time or interest for self-initiating, it contributed to the discontinuation of care and referring out of clients with disabilities by first having a conversation about the counselor's lack of competence and the ***recommendation of services*** in the client's community. For instance, Sarah acknowledged her lack of skills and interest as factors informing her ability to self-initiate with clients with Autism. Even though Sarah emphasized the importance of referring out based on best client care, her excerpt showcases the dangerous and ableist exclusion of an entire group of people. On the other hand, Jerome, Reece, and Unice emphasized the need to hold honest conversations with the clients and show mutual respect by providing meaningful recommendations when collaboratively deciding to seek out services.

SARAH - Well I know for me, any time I get a call on someone who is a child or teenager who has been diagnosed with autism, that is something that I'm very particular about. I don't feel like I have any competence in that area and it's not an area that I'd like to get competence in. I do refer out for that particular population because I just ... I don't have the skills. I don't want the skills. I don't have the competence to be able to deal with that particular population, so I do refer out.

JEROME - I have a client come in, I meet them, it just doesn't seem like it's a good fit. Their personality doesn't work with mine, my personality doesn't work with them. As the therapist, I would try to figure out what that is about and I'll try to push through that, but then if that doesn't seem to make things better, I would probably have a conversation about that. I would say, "Listen. I don't know what's working, I don't know what's not, but it feels like something here is not working," and I would have a conversation about it.

REECE - If we're not you know, helping the client anymore then we're gonna try to see what other resources we can link them to. Like where else can they benefit, where else can they get what they need if we're not helping them anymore. So yeah, and if there's family involved we might talk to them to get their input. Ultimately it's the treatment team's decision.

UNICE - There's an un-comfortability that exists in the session and if we don't have it, it is our duty, in order to provide the proper services to this client, whomever they may be, whatever they may be dealing with, it's our responsibility to find the resources, to connect them, and to maybe later on educate ourselves, so that if there ever is another encounter with a similar situation, we can be better prepared.

Furthermore, when reflecting on the process of ethical decision making, Queen further emphasized the need to come to terms with one's assumptions and actively seek out supervision to increase competence, as with any other multicultural group. Also, Lynn described the resemblance of disability and other cultural groups that are part of multicultural competence and highlighted the public visibility of ethical decision making that impact minorities' access to counseling care.

> QUEEN - I think similar to just the idea of it. If we look at this similarly to multicultural competencies, that you would look at this the same way with some level of responsibility to have some baseline of a competency with it.

> LYNN - So you know, just in the way that people need to develop competencies to work with persons of other cultures, other sexual orientations, other gender identities, I think that it's really our job as counselors, our ethical responsibility to develop skills and competencies to work with people with different kinds of disabilities. But I think that sometimes people use the, you know, the ethics surrounding competencies and people's area of competency as a way to avoid working with those clients. And so I think that that's like an ongoing challenge when it comes to ethics and counseling. […] it's an interesting thing because you think about like those people who, in their training programs, refuse to work with people who identified as LGBTQ, and, you know, those turned into, like, lawsuits that got national attention. I am positive that there are plenty of people who are saying, not for biblical reasons and maybe that's the difference, but like, you know, I can't work with these people with disabilities. And like, even if their reason is different ... Maybe it's not because of their beliefs, but because of their ability, it's like there still is a problem.

As the participants described their ethical decision making process when working with clients with disabilities, they also reflected on the community resources to which to link these clients. The next analytic factor, **Client's Community**, describes participants' views of the community pieces that go beyond their professional village and that encompass the community organizations by and for people with disabilities.

Client's Community

In general, participants recognized a disconnection between their professional community and the organizations at the client's community level. The addition of this analytic framework deepens the interpretive understanding of the counselors' village that extends beyond their professional community. This analytical factor encompasses the dimensions of ***disconnection between the counselor and client's community*** and the ***lessons learned from the disabled community***. Figure 13 illustrates the disconnection between the professional and client's community as reported by the participants, as well as the lessons learned when the counselors have engaged with the client's community.
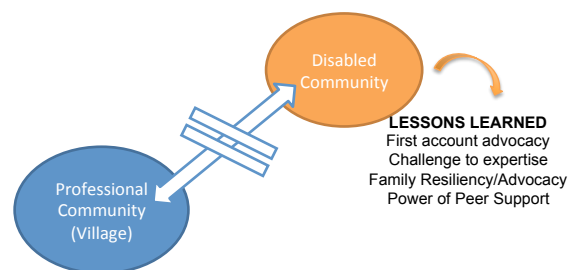
Figure 13. Client's Community

The majority of the participants described a ***disconnection between the counselor and client's community***. Participants expressed their lack of knowledge about and engagement with client's communities as well as their hesitance related to the steps to take to approach these communities. From the excerpts below, Eliza, Faith, and Reece explain their lack of experience

contacting their client's communities, which results in them remaining within the boundaries of their professional village when working with clients with disabilities. Unice and Jerome highlighted the potentially detrimental disconnection between the professional community and the client's community as it removes opportunities for access to services and counselor advocacy.

> ELIZA - I've communicated with someone's interpreter, but then, at the same time that's still a professional, right? So, no. I haven't.

> FAITH - I don't think [I have contacted the client's community]. Not really, no. Not for me. Again, just because I don't have had a lot of experience working with the population.

> REECE - I probably haven't directly contacted resources in the community but let's say, you know, I have a client that's interested in, you know, going to a group like an arts and crafts group. I'll just talk to them about the benefits of going to the group, kinda stimulate them, encourage the conversation as far as like where they can go for this group, so I'll talk to them about that kind of stuff but ... and then I might remember that this resource is out there and then use it with another client if it applies.

> UNICE - [connecting with the client's community] can be challenging, it can be a very daunting task, but I think again ... my experience has been that I have tried my best to stay connected with my community. And sometimes my community provides me with the resources and the knowledge that if they're not able to offer what I'm looking for, that they can connect me to someone else who can. And I think that piece is so crucial to the treatment that we provide because if we're not connected and we isolate ourselves then we're not able to offer our clients all the benefits that they could be receiving.

JEROME - Honestly, I probably haven't been connected to the disability community all that much. I think one of the problems with any organizations is they are very focused on working with the community itself. One of my friend's moms does a lot of disability advocacy, and she goes all over the country and does a lot of this. She does a lot of things here to bring awareness to disability and disability rights, and I'm aware of what she does. I don't think I have ever sat down with her and talked to her about how to help folks with disability in counseling. I'm not sure why I haven't, but I think that part of it is that I don't see terribly many folks with disability in what I do, and it's not where I would need to focus my time. I think this other piece of this is, I should be reaching out to my connections in the disability community. I don't, because I don't see terribly many people with disability, but I should do that. I think having conversations like I'm having right now, it brings it to light, unless we're having these conversations and not thinking about the things I could be doing.

As a researcher informed by disability studies, I considered Jerome's and other participants' comment to be significantly illustrative of the missed opportunities for the counseling profession to better prepare counselors to understand their work as not exclusively centered in the counseling office. When participants have engaged in the client's communities, they described several ***lessons learned from the disabled community*** that increased their level of competence to work with other clients with disabilities. First, participants mentioned the power of listening and witnessing clients' accounts of their self-advocacy for their needs while also reflecting on their engagement in critical thinking about claims of expertise in treatment decisions. Queen explained her recent awareness building experience as she attended an activism session by a person with a disability who described his lived experiences and advocated for

needs related to autonomy and dignity as a person with Autism. Queen further described how listening to this person amplified her frameworks to critically think about the power of specialized and scientific knowledge and its impact on the disabled community.

> QUEEN - So because I had worked at an independent living center, the clinic that I was at, we would have an annual professional development conference, and there was a young man who came in and spoke to us. He was from the western New York region. He was a person with autism, and he had been, actually he might still be in a supportive apartment situation, but he really spoke about the Autism Speaks movement, and how he felt that was really detrimental to him and his peers as they moved into adulthood, and how it was really a single-focused force. It was for parents who were advocating for accommodations for their students, for their children more than it was for having an appreciation and recognition for the diversity of the unique individual. So he really kind of talked a lot about that and his need for more autonomy, and some of the patronization that comes with some of those. So for me, it's another thing that's challenged me to kind of look at who am I even seeing as an expert, and who am I even seeing as a resource and being able to try as these things present themselves, try and be more attuned to some of the competing thoughts about what's really gonna be beneficial for a unique individual because I think at times they come in direct conflict with each other, both of those movements. So I think there's that. Not necessarily that I'm specifically driven to learn more directly from him, but I think for me, just the idea that, yeah there's these valid competing ideas and philosophies about how you do look at this stuff.

When engaging in the disabled community, participants also commented on its positive impact on their competence to work with clients with disabilities after getting immersed in the

narratives of families' resiliency and advocacy for access to services. For instance, Cortina provided an example of her work with a mother who actively worked to optimize the power of her community in the service of the needs of her child who has a disability. Cortina expressed respect and appreciation for this family's story, and positioned this as a factor that has enhanced her level of competence to work with clients with disabilities.

> CORTINA - I know one example when I worked with the mother and I had seen the daughter and she had a central auditory processing disorder but that's another type of developmental or cognitive disability and from the mom's story of her connection with support groups and self-education on this topic with the psychiatrist, with the doctors, with even the swim coach because the child is in swim, from the mom explaining how she put that village together to help her child, helped me learn.

Finally, participants also reflected on their realization of the power of peer support for disabled clients once getting to know the positive impact of peer support within the disabled communities. The potential of peer support was often equated to the potential for self-advocacy. For instance, Lynn described an example of her client's engagement with a peer group that provided support by and for people with chronic mental illness. Lynn stressed how she gained a deeper perspective of community organization.

> LYNN - I think that especially ... like clients, any client, no matter what it is that their, you know, presenting concerns are, no matter what their, you know, demographics, should be encouraged to engage in some level of peer support and peer and self-advocacy. And I think that, like, those were some of the places where I had an opportunity to do a lot of learning.

As participants reflected on their ethical commitments as well as their further engagement with their clients' communities, they also considered their own privilege and their role as representatives of the mental health system in the counseling room. Participants described realizing how their own privilege has served the purpose of enhancing competence to work with clients with disabilities in different dimensions. These dimensions are identified and described in the next section, **Understanding and Using Privilege**.

Understanding and Using Privilege

The majority of participants mentioned the realization of their able-bodied and able-minded privilege when working with clients with disabilities. The realization of able-bodied and other privileges related to social class, education level, and language spoken, defined for the participants a two-tiered purpose of the use of their privilege, ***to remain aware/sensitive***, and ***to notice how the system fails the client***. Figure 14 illustrates the dimensions and sub-dimensions of the participants' understanding and use of their privilege.
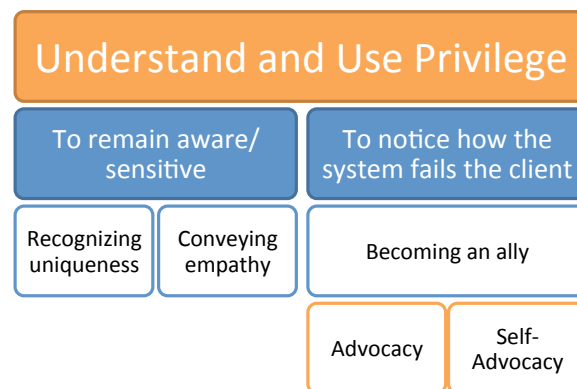
Figure 14. Understanding and Using Privilege

Participants described how their acknowledgement and processing of privilege in the counseling room with their clients served the purpose of fostering awareness ***to remain sensitive*** to the client's narratives. Many participants explained that they have never experienced the world

as a disabled person, but emphasized the ability to understand the clients' emotional experiences by positioning the clients as experts and educators of their own experiences. Specifically, the participants named their best intention to understand as much as possible from the clients' descriptions and articulate their resources to help the client resolve their emotional distress and counseling concerns through empathic understanding. Within this process, the participants highlighted the importance of recognizing the uniqueness of the client's lived experiences, as well as the need for counselors to remain attuned to the clients' difficulties. Maria and Sarah emphasized the importance of cultivating empathy for the client's stories and experiences. Additionally, Maria explained the importance of positioning clients as the expert and teacher of their own stories and experiences, whereas Natalie highlighted the importance of a continuous checking of assumptions and reactions.

> MARIA - I think to a degree it [recognize privilege] really does help with the empathy part. But, they are right, I don't know what it's like to be in a wheelchair. There are things that are completely different and what I deal with and what someone else deals with is different.

> SARAH - I think it goes back to being client-centered and really identifying what the feeling is. Like someone who has addiction. I myself as a professional may not have dealt with any addiction in my own life, but I can identify with loneliness and I can identify with feeling sad and I can identify with anger. I can get back to identifying that. Boiling it down to that underlying feeling. I think the same is true for someone who has a disability understanding the desperation. I can be very honest. I have no problem telling a client, "You know what? I don't know what you're going through." Come from a curiosity type

of framework where, "Tell me what that's like for you." Even if I had a disability, my disability might be something different.

NATALIE - I don't understand it because you tell me something and I instantly memorize it, know what it means, can probably analyze it, and go deeper analysis of it like layers. It's frustrating. I think I was getting frustrated with the students, recently too because also, they've been handed students with learning disabilities in high school literally have been handed everything on a silver platter because their parents would advocate for them so much to the point where people ... The school is afraid of getting sued or they just didn't want to hear it anymore. The teachers would baby them. I'm working with students counseling in capacities that's not exactly clinical all the time. They have to make a PowerPoint or they have to make a flier for something that we're doing advocacy-wise on campus. They're not editing their own work. I think a lot of it as laziness and they even admit it. They could easily edit it and then still have some mistakes. I would gladly go back in and re-edit it for them or re-explain something to them, but I have been getting very frustrated and I've been trying to decide, "What parts of them are lazy? What parts of them really just don't get it? What parts of them are just frustrated that they don't get it, so they stop trying to edit?" I've been trying to check my privilege and maybe be annoyed in my head for a little while but then try not to let it seep into my work with them at all. Because I don't really know where it comes from in them and I'm not doing long term clinical work with all them to dissect that, but some of them do it being lazy and being catered to in high school. There is frustration there for me. I do have to continually check my privilege in that. I am super smart, just didn't have to ever deal with that. I'm like

215

"Okay. I don't really know where they're coming from. I can't necessarily judge why
they're acting one way or another." I feel like that's my biggest struggle.

Furthermore, participants described how understanding their held privileges helped them
notice how the system fails their clients. By recognizing how their clients have been oppressed
by the system, many participants tended to honor their commitments for social justice by
positioning themselves as allies in their clients' lives. Also, Peter shared his insight about the
rehabilitation and vocational system sometimes failing his clients.

> PETER - I feel like many times that the disabled get victimized and re victimized. Why
> do I say this? Because many times, and this is an example, you can go to AccessVR and
> you can get a vocational rehabilitation counselor assigned to you that likes you and they
> will do everything for you. You can get one that doesn't click with you and they will sit
> on your stuff and they will make it like pulling teeth to get stuff done. They'll make you
> jump through hoops and assessments and it will take forever to get to the ultimate goal.
> The same thing happens with Medicaid. You get a good worker and the worker likes you,
> you'll get everything. I feel like these people, by default of just being a person with a
> disability, have been victimized so many times from kindergarten, first grade to whatever
> age they are. They are always at the mercy, or not always but many times at the mercy of
> outside systems.

Becoming an ally seemed to stimulate the participants' engagement with the client's
immediate communities, spark the counselors' initiative for advocacy in their professional
communities, as well as increase counselors' investment around clients' self-advocacy skills.
Specifically, participants defined advocacy actions as: Initiating conversations, educating their

communities around disability issues, and promoting disabled clients' access to services in their own places of employment.

Several participants' excerpts substantiate this emerging analytic category. For instance, Tela commented on how her own acknowledgement of privilege has assisted her in identifying and challenging stigmatizing conversations in her job place about clients who experience addictions. Also, Natalie equated her realization of privilege to the enactment of social justice commitments and becoming and ally and advocate for the needs of clients who are marginalized. Natalie further expanded the applicability of being an ally in the LGBTQ community to the disabled community.

> TELA - I think acknowledging it [disability issues] with colleagues, especially within the substance abuse field, working in a medical setting. There's a huge amount of cultural stigma, and a big part of that is being willing to have conversations with colleagues or with the nursing staff about language and the power of language and how that has a potential impact on patients we see, how that has a potential impact on not only the patients but the co-workers that might be struggling with these kind of issues, you know? None of us are living in a vacuum. We're all exposed to addictions or mental health. You're just trying to build ... the same kind of thing, really. Being willing to have a conversation within the system and ... you know, in a way that's disruptive.
>
> NATALIE - I think being an ally in the LGBT community, which is the same as for people with disabilities is that understanding where you are and how you're different. You have to understand how you're different, then you have to understand your privilege in this culture. You have to understand their culture and fully, really, look into it like "Yeah. I totally get what life is like for black people. I totally get what life is for a

transgender person. I totally get what life is like for someone in a wheelchair." Really get to know people in the community and really get to know what their life is usually like. You can't ever know everyone's life, but you have to educate yourself. Those are all parts of being an ally. I think another part, which is essential is the advocacy. It doesn't necessarily have to be any specific type of advocacy but that your heart is in a place where you would stand up for someone whether it's advocacy that you actually go to a march with someone or go to a meeting for someone with disabilities and help them get what they need from the system or go join a committee that helps make decisions for them to make the school better or the county better, or the state better. All those things are advocacy. Maybe it's something smaller, maybe it's just supporting them in a way where every single time you enter a conversation with someone and someone says something like obviously uneducated or biased about persons with disability or any other oppressed group that you stand up for them. You help educate the rest of the world and that's advocacy too.

The majority of the participants acknowledged the productive nature of realizing their privilege and using it to disrupt the ways in which the system fails their clients. Some participants offered concrete examples of the specific advocacy actions enacted in their clinical practice. Unice explained her work around understanding the limitations of a system that fails to accommodate a variety of language needs and advocating for clients who do not have access to services for this reason. Queen described their advocacy work at the policy level as a higher education administrator. Also, Henry explained his advocacy efforts for clients with disabilities from the position of a supervisor.

UNICE - Because I work with the Hispanic community and I'm limited with some of my resources that I can offer, sometimes I have to step outside my scope of practice an sometimes I have to provide advocacy that you said gets mentioned and it's a very important one because sometimes my clients don't have that capability. Sometimes they don't have the right language or the ability to connect with someone, where in turn I do. It's a very important role because of the way it's perceived within the community.

QUEEN - Well I think a lot of it is, particularly because of my role as an administrator, which is I don't divorce from my role as a counselor with these students, but being able to sit at a table and these policies being discussed, being able to interject with how that may impact the student who is experiencing life with a disability, and I'm in the student affairs division so there's a lot of additional tension and diversity, equity, and inclusion in making sure that disability is something that remains a conscious focus within disability, equity, and inclusion. That it's not the ADA and IDEA and the Fair Housing Act haven't taken care of it so we don't have to think about it anymore. So I think it's been helpful for me to be able to kind of collect an understanding of these experiences and influence how the conversations around policy and process and institutional change move along because I'm able to interject with how other students who are represented within the disability population, are impacted.

HENRY - Well, the good thing is like with my position, especially now because I have the position also of a supervisor, I advocate in behalf of my clients because I'm connected to other community agencies. And I do provide ongoing education to the community, and I've also done supervision. And also the supervising also help to educate individuals and

advocate on behalf of their clients that they're working with sometimes. So those are some of the things that I do.

As it is evidenced in Figure 14, an important component to the counselors' role of an ally is that of a promoter of self-advocacy skills for their clients. Participants defined self-advocacy as the clients' encouragement to learn and use skills aimed to represent themselves and their needs in their immediate contexts. Unice and Natalie's excerpts showcase the counselors' intentionality to model, encourage, and promote the enactment of self-advocacy skills in their clients.

UNICE - So I give them the opportunity to make that attempt first, I stand by my clients and I try to advocate for them as best as possible. And we do this together so that they can learn for themselves how to go about doing it. I want them to learn as much as they can. So I have to make sure that I'm teaching them these skills so that once the therapeutic environment has ended, and if they ever come across a situation where they have to reach out through the community, and they have to advocate for themselves, that they can do it confidently.

NATALIE - ... I think that was the first time, the past two years, where I was really engaged with advocating for them within the Suffolk Community College and also, very interested in seeing how they can advocate for themselves outside. One of them is very involved in Special Olympics and that definitely helps her self-esteem.

Moreover, a few participants further mentioned the difficulties to engage in advocacy actions for their clients given their work demands and lack of time. In the excerpt below, Jerome explains the distance of his counseling role from the role of an advocate, and he situated lack of time as the main reason to not engage in advocacy work for his clients. Kara also stressed the

limitations related to time in her schedule to dedicate it to advocacy activities, whereas Eliza

named her commitments related to advocacy and the need to work on it.

> JEROME - I don't really see much of a role, to be honest with you. I think I can advocate
> from when I talk to my friends and other people, but I really put myself in their therapist
> role. I'm here for them. If there's things I know ... I have a couple folks with autism. One
> of the big things with autism is there's a lot of social isolation. I'll generally make
> suggestions for them; things they could do to not be isolated. I would say that I don't tend
> to do a lot of advocacy work for the folks I work with, or I will tend to make suggestions
> to the connect folks to things, but I don't tend to do a lot of advocacy. I don't think I really
> tend to do any, actually, unless it's just on a personal level, where I'll talk to people. Part
> of that, for me, is probably I'm just so busy with everything else I don't have time to add
> another thing to my plate.
>
> KARA - And I might fight a little bit more for them once I realize that. Because there's
> such a lack of time at agencies for this stuff. Those are usually the times that maybe I'll
> find myself staying late. Or doing things off the clock. Because I see that it's ... like that
> one client I see how necessary it is.
>
> ELIZA - I feel like an ally is being supportive, empathetic and understanding to
> someone's situation no matter what it is. So, I feel like I am, but maybe not enough. I
> think that I need to work on it.

As participants reflected on their privilege in the counseling relationship and their

potential for advocacy for clients with disabilities within the mental health system, they asserted

that the therapeutic focus and advocacy efforts are informed and defined by their clients'

expressed needs. Thus, in planning on what to attend to in counseling sessions with clients with

disabilities, participants described different factors that inform these clinical decisions. The following and final additional analytic factor, **Counseling Focus**, illustrates the participants' descriptions of this topic.

Counseling Focus

The participants described the counseling work with clients with disabilities as a scenario that is mainly guided by the client's lead and that is reflected in the specifics of treatment planning. According to the participants, this therapeutic scenario represents different narratives that contrast and overlap at different points of the counseling work. The main narratives presented by the participants that informed the dynamics of the counseling focus with clients with disabilities are: ***system's fantasies of cure*** and ***counselors' intention to embrace difference***. Figure 15 illustrates the reciprocal dynamics of the Counseling Focus as well as the properties and descriptors mentioned by the participants.
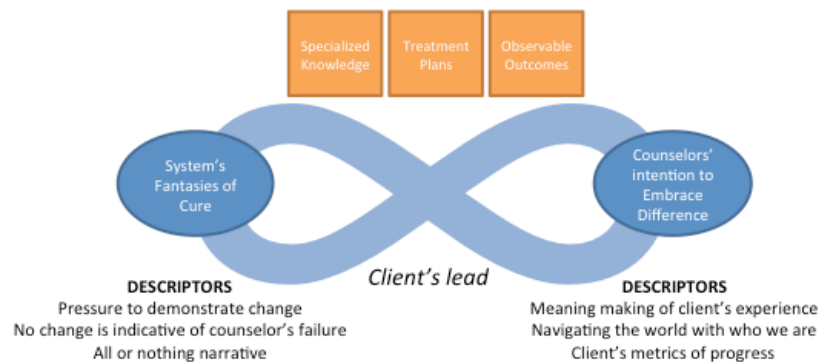
Figure 15. Counseling Focus

Participants described the counseling focus as abiding to different narratives present in the mental health discourse. Some participants described counseling work responding to ***system's fantasies of cure*** that supported the idea of resolving mental health issues and eradicating the impact of disabling conditions in order to regain functionality. Here, some participants expressed

the pressure to demonstrate observable change in the clients' level of functioning to counter the idea of the counselor's failure, as well as the presence of all or nothing narratives when it comes to physical or mental functioning level. For instance, Allison highlighted the importance of recognizing the imperfect dimensions of the human experience and acknowledging one's true identity. Kara stressed the struggles of demonstrating competence as a counselor with clients who do not adhere to the change expected by the system. Moreover, Lynn offered a compelling personal example of her experiences and reflections about systemic normative expectations for cure and all or nothing narratives.

> ALLISON - I mean if you are having, if you are suffering from a disability more than likely you are going to have it all of your life. So for me, my goal for everybody is to acknowledge and accept that this is what is happening to me. This is what I am working, what I am going to travel with for the rest of my life and when those moments arise that it hurts me or I get anxious about it or I am angry about it. How do I deal with that? And if you are able to say and identify and use your coping skills and you feel like you don't need to come and practice and talk about it then that is on you. That is when you graduate treatment. But I mean the truth is that if you can't accept, if you are struggling with accepting that I am going to have this, you will constantly need therapy. You will constantly need to work on it because you haven't acknowledged who you are.
>
> KARA - So, it's definitely an internal struggle for me where I believe it would be beneficial for [the client]. But also respecting that he does not want to at all. So again, it's always meeting him where he is at. But it is ... we do have treatment plans and whatnot and it does make ... I think maybe this is part of it. It's almost reflects me as failing.

LYNN - I think that for me the biggest lesson was with my parents. You know, both of my parents had cancer and died from cancer. My mom, in the course of her cancer treatment, lost one of her legs and was […] trying to learn to walk on a prosthetic, and there was like all this encouragement like, I know it's hard and like I know it's painful, but once you can get the knock of it, then you can just be back on two legs and like ... If you wear pants, nobody will know the difference. And the reality was that it was really hard and it was really painful and my mom felt like she was spending all of her time, you know, all of her lifetime for which she didn't know how much she had, you know, trying to master this skill. And so, at a certain point she just stopped. And for a while all of us as a family felt like really sad about it, like there was just like this prosthetic leg with like her shoe on it in the corner. And she just didn't use it. And we felt like, you know, she had quit ... Or like she didn't want to get better. But then like somehow in the midst of us, like obsessing about that, she did get better. Not at the leg, but she got better. She like could zip around on her little wheelchair. She stopped covering up her amputation. Like she went to the grocery store and instead of wearing two long pants in the summer, she would wear shorts and ... And so like she got better. And it wasn't in the way that people had said she would. She didn't get any "normal". But she just became and lived fully this new life. And then, like a few years later when my ... When she died and then when my dad died ... And my family at first, one of the ways we coped with that was we would go to like a lot fund-raising events and so we would go to like the Race for the Cure, and like the Walk for the Cure, and all the people who would speak would be like people, like survivors. And there was all this language about like "I beat it", like "I won". Like if you're strong, and if you are really committed and you're really passionate, like you can

beat cancer. And then like let's also take a moment of silence for all of our friends who like lost their battle. And I just think that that language is so problematic. It completely minimizes, you know, if there's anybody out there who thinks that the reason that my parents died from cancer is because they didn't want to win ... Like I would love to punch them in the face. And so I think that those experiences like influenced me a lot in thinking though, you know, like ... I don't know ... Like people have to learn to live with the traumas that they've experienced. But is it like ... Is the most important thing that they feel like they won? Like aren't we just like setting people up for this like completely all or nothing experience? And so I definitely think it's that way, too, with disabilities.

As evidenced in Lynn's illustration of her personal experiences, all or nothing narratives that surround the disability can often misguide interpretations of healing and wellness. Lynn further amplified the importance of dismantling these narratives in the counseling work and processing their potentially negative impact on the lives of people with disabilities.

Participants consistently highlighted the ***intentionality to embrace difference***, which is situated in the counselors' positionality in the wellness model. According to the participants, counselors worked towards wellness and embracing difference in order to affirmatively integrate client's differential levels of physical and mental ability. Starting with the clients' current abilities provided a foundation for further development, growth, and resiliency by building upon small goals. In doing this, participants stressed the importance of meaning making, learning to navigate the world with one's own set of abilities, and defining progress according to the client's metrics. DDD and Iris emphasized the need to work towards a healthy and affirmative integration of self that brings fulfillment to the client's life based on the client's strengths. Also, Sarah stressed the importance of an individualized and client-centered approach grounded on the

client's subjective experience of treatment, even when these impressions can counter systemic expectations.

> DDD - I think for some of my clients, they really do have to come to terms with their abilities as they are, and once they can explore that aspect of themselves or integrate that aspect of themselves, I guess that would be more of a goal of mine, is to help them integrate their disabilities into their life. Maybe for some people that means being able to rejoin the workforce or overcome the problems that have been imposed by their disabilities. For some people it might be more of just really helping them get to know certain aspects of themselves or their functioning or their life outlook or their abilities, because maybe they haven't been able to explore that or learn that side of themselves. […] In some sense, I can support to overcome problems but I'm looking for a healthy integration of a self, which I think includes quote/unquote "good/bad" aspects of the self. I don't know, maybe it's a little existential or something but I think some of it just has to do with being able to be okay with what is, and so, in some sense, if somebody wants to overcome something, great. I'll see what I can to help them do that, but I think that it gets confusing, because that's not an easily defined concept. […] In general, when it comes to disabilities, I guess the way that I could generalize, something that I keep in mind, is just a healthy integration of self and others.

> IRIS - That they want to work, they want the fulfilling relationship and if those things are not happening for them for whatever reason. Right, for whatever reason. How can they have the most fulfilling life that they can. How can they process their emotions and reactions around the things that they want and don't have or ... Yeah, your basic treatment

to being the best they can and being fulfilled to the best that they can with their own

strengths and what they have inside.

SARAH - On the flip side, if you're dealing with someone who has got a brain tumor,

their level of success would be very different and even different within ... Really within

each individual client. You have to really specialize. What are the outcomes for this

particular person? Really base it off of what they think is successful. Again, I think you

have to go back to a client-centered approach. When you're treatment planning with

someone about how would you know that you have been successful within your

treatment? I take it back to them. I think it is much more subjective than it is objective. I

know that is probably what most [agencies regulated by the Office of Mental Health]

disagree with.

The nature of the counseling focus was not entirely situated in a dichotomous framework

(i.e., normal vs. abnormal, healthy vs. pathological) but rather, it was more fluid and dynamic for

participants. Therefore, participants described the reciprocal interactions between the system's

fantasies of cure and their intentional work around wellness and embracing difference when

enacting their professional role in the mental health system. For the participants, the articulation

of the counseling focus was grounded in the cultural products of managed care and third party

reimbursement (i.e., billing goals, diagnosis), which inform the prominence and authority of

specialized knowledge, *treatment planning* and *observable outcomes.* At the same time, the

counseling focus described the importance of clients' wellness, development, and resiliency.

Likewise, participants described their navigation of these reciprocal dynamics depending on the

demands of their specific sites of employment as well as responding to the *client's lead*.

All the participants quoted below stressed the importance of following the client's lead in the design and delivery of counseling treatment. For instance, Natalie and Gloria emphasized the importance of letting the client guide the conversations and the need for counselors to refrain from determining the goals for counseling. Brittney and Henry described their articulation of the specifics aspects of counseling interventions through treatment planning which respond to the client's expressed needs.

NATALIE - About what the patient wants. What do they want to do? We can't necessarily make them pick a part their feelings about their disability. Unless that's what they want to do. Maybe they just want to fix one area of their life and say, "Oh, I have a disability but I just really want to get back to work." Just bringing some confidence in myself, but they don't want to go into all this deep shit.

BRITTNEY - We sit with the client and we ask them, "What are your goals for treatment?" Some of them say, "I want to be independent. I want to live on my own. I want to go back to work. I want to fix family relationships. I want to engage in my community." Usually, we work on two goals, and then we have objectives. The client says, "I want to go back to work." The objective will be, I'll report two actions I have taken per month that will aid me in returning to work, such as building my resume, filling out job applications, going to the library, and using their computer services. We really let the client take the lead with that, and then every time we meet with them, we would discuss their progress towards those goals.

GLORIA - It's not me saying oh this is how you have to be or this is what normal is or this is what's expected of you. It's really saying what is it you want and how can I help you get there?

HENRY - Well, basically what the client wants to work on is what's important to me. Sometimes clients don't necessarily come to see me wanting to overcome their disability, I guess. Like they may be coming to see me for a different reason, so maybe depression, which may be impact of the disability or anxiety or feeling disconnected from the community.

The participants widely recognized and claimed their intentional affirmation of client's identity and strengths in their work with clients with disabilities. Participants also emphasized their commitment for client-centered approaches that would foster client's lead into the counseling treatment. This participants' intention might be problematized when legal guardians and other parties are involved in the decision making process of client's treatment goals.

As participants reflected on their counseling focus as well as the other analytical factors emerging from the second round of interviews, they organically built and named the linkages to other aspects of the existing analysis. The next section presents the interpretive integration of these emerging analytic factors into the existing themes or categories, which had emerged during previous rounds of data collection and which evolved as the participants engaged in the research process.

Evolution and Refinement of Previously Established Categories

During the second round of interviews, the participants further described and dimensionalized the existing themes within the analysis. Moreover, in these interviews, the participants spontaneously linked the additional analytic factors to the existing categories and provided examples and confirmations of the importance of factors mentioned in previous interviews. Therefore, the participants' evolving narratives in the categories of **The Therapeutic Work**, **"It Takes a Village,"** **Evolving Commitments**, **Competence**, and **Systemic**

Dimensions was captured and further expanded based on the explanation of their experiences. This expansion, integration, and dimensionalization of the existing categories and the additional analytic factors are presented subsequently along with substantiating participants' excerpts.

The Therapeutic Work

During the second round of interviews, the category **The Therapeutic Work** was consistently reflected in the participants' narratives of their work. Participants highlighted how their thoughts related to ***disability as an identity*** have progressed and become more intertwined in their role as professional counselors. For instance, Queen highlighted her advocacy actions around the creation of inclusive practices within higher education by acknowledging the unique experiences and needs of students with disabilities. Moreover, Unice reflected on her own emerging process of identification of alcoholism as a dimension of disability identity in her clinical work.

QUEEN - [Accommodating for ASL interpretation] is not something that the college typically does, but I said, "If we're talking about being inclusive, we're going to have sign language interpreters at the event." This work demonstrating this level of inclusion is about creating a culture where students recognize that we value them feeling welcome. So that was one piece. I think another way is really being able to support the efforts of other staff who created a social skills, social awareness group for students who identify as being on the autism spectrum.

UNICE - A little while ago, I remember when we first began our conversations and you had asked me about different disabilities that I had encountered and I never connected disability to alcoholism in the community that I work with. Because in my experience, I've never had that connection to that type of ... the wording, for me, was different, the

disability, whether it was alcohol or drug abuse, I never looked at it as a disability. It was more like a disease, I had a very hard time connecting those two together because the word disability to me meant something different than the way I perceived alcohol or drug abuse.

Additionally, during the second round of interviews, it was evident that for the participants, the categories of ***disability as an identity*** and ***disability as a cultural group*** were strongly related to their conceptualizations of the additional analytic factor ***client's community***. Queen's previous statement demonstrates the actions related to recognizing disability as a legitimate identity within campus, and can be extended to the edification of disability as cultural group and particular community within campus. The analytic factor of ***client's community*** will be added to the theme **"It Takes a Village"** later in this analysis.

The participant's continuous recognition of disability as an identity with unique needs led the participants to further highlight their ability to strengthen the ***counseling relationship*** based on their increased attentiveness to their client's unique needs. Also, the participants described their sustained attention to the potential of the counseling relationship while honoring their commitments for ***tailoring their approach*** based on the specific and stated needs of their clients. Queen described the progression of her level of commitment to remain grounded in the clients' needs and attuned to some of the social challenges they might be experiencing in higher education as a result of their disability. Moreover, she amplified her deepened commitments to attend to client's specific conditions that inform the client's reactions to the environment, and therefore, tailor the approach to better the students based on their particular needs. Additionally, Iris offered an example of her evolving responses as a professional counselor tailoring her

approach (i.e., to include the collaboration with case managers) to meet her client's relational goals.

QUEEN - Well I think just being able to have a little bit more of a, I don't know if it would be called a first-person sense, but I think it helps me be more attuned to some of the social challenges that may be impacting them as a result of their disability. So certainly for us in Higher Ed, you have students who are ... They may have a spectrum disorder or they have some sort of just academic learning disability or they do have PTSD from something, and the fire alarm goes off, and it's a panic attack and there're all these things that are just unique to them living in the college environment, and in the social aspect of that is, I think because of the developmental stage for most of these students, is so much more acute. It's impacting them so much more that I think it's having these personal interactions help me continue to stay attuned to, "Okay yes, I appreciate why this would be so distressing," because just pulling and reflecting from some of those things I think is helpful.

IRIS - Can think of a couple of anecdotal things right now. I have an elderly woman with a disability, mental health and cognitive I believe, and lives on her own but with an assistant and wants nothing more in life than to have a fulfilling romantic relationship. Now that has never happened for her. She daydreams about it and maybe it will. She will talk about it and she talks about past experiences and where does she want to go want to be. What does she want to bring to the table and talk about? What's causing her some angst? It isn't the relationship as such as some other things but that's there too. […] It has got to be within their framework of what they want and are able to do and a lot of the avenues that are available, so sometimes it's doing little case management. Hooking

people up with services that can help them increase their social life. Increase their work life. If that's what they want.

Furthermore, during the second round of interviews, it was evident that the counselors' ability to *tailor the approach* interconnected with the *counseling focus*, yet one influenced the other based on the client's lead. For instance, when participants focused the counseling interventions in either the system's fantasies of cure or in the counselors' intention to embrace difference, participants had to tailor their approach to respond differently to the client's expressed needs for treatment. As explained in the first section of this chapter, the participants presented the *counseling focus* as the set of forces that inform the interventions in the approach to the work with clients with disabilities.

In summary, the participants highlighted their progressing commitments to tailor their approach by accurately capturing the client's needs through the counseling relationship, and connecting with their professional community or village to acquire information, consultation, and skills needed to deliver effective counseling interventions. During the second round of interviews, the participants also made reference to the existing theme of **"It Takes a Village."** The next section presents the participants' expansions of this category.

"It Takes a Village"

In the second round of interviews, **"It Takes a Village"** emerged as one prominent category that reflected the participants' ongoing connection with their professional community or village when developing competence to work with clients with disabilities. Specifically, the participants highlighted how their *collaborative relationships* continue to evolve within their experiences working with clients with disabilities. Peter's excerpt below demonstrates how expanding his connections to the professional community as a mental health counselor has

helped him navigate the options to find answers and services for his students' needs. Unice

further highlighted how these collaborative relationships have stood out for her in granting

support and preventing counselor burn out.

> PETER - Since I'm very holistic in practice, I almost traverse mental health counseling
> and social work. I almost do dual roles, what might not be considered the job of a mental,
> licensed clinical health counselor or a licensed clinical professional counselor. What
> might not be considered the role of that person in terms of services and reaching out to
> collateral contacts, meaning referring them to services and helping them with welfare or
> helping them to apply for SSI or to help them appeal and help them with a lawyer, just do
> a whole bunch of different services. I could go on and on and on about the services that
> I've helped people with, housing and just all kinds of benefits.

> UNICE - And I think that after awhile, sometimes that's how we can become stuck in our
> therapeutic services that we offer, because we are not reaching out. We can't do it alone.
> In this field, it's very easy to burn out, to become exhausted, to become overwhelmed,
> and if that's where we're heading to, again, we have a responsibility to ourselves and to
> our clients to gather as much information, to make it a collaborative effort so that if we're
> not able to provide whatever it is that they need, we can reach out to our community
> which is right outside our door. Sometimes it doesn't take that much, just staying in
> contact with certain agencies, or even just beginning relationships, introducing ourselves,
> networking, just keeping abreast. That can open so many doors.

Along with Peter's descriptions of the evolution of his collaborative relationships,

participants also corroborated their increased intentionality around accessing their ***learning***

communities. For instance, Unice highlighted the evolution of her professional responsibility to

stay updated and knowledgeable by remaining in connection with the professional community. Unice further highlighted her ability to network through social media.

> UNICE - I think it's our responsibility to keep updated, knowledgeable, on different situations that we might encounter when we being to supervise treatment of clients. Again, our community would be the first and closest resource. But then there's so many other resources that sometimes we need to becoming involved in. You know, groups that really focus on specialized training and things of that nature, and sometimes it's not that easy to find, but I think that collaborating with others and kind of networking and kind of keeping abreast of some of the changes that take place, I think that's so important. I know that for myself I use social media, it has different groups focused ... my specialty right now is anxiety and depression and trauma, so I try to follow individuals in the field who are conducting research and staying abreast of all the new information that's being provided.

Participants further described their evolving intentionality to attend to ***clients and families narratives*** in order to better understand their counseling needs. Overall, participants positioned the counseling service as the place to capture these needs that will be further met through the participants' connection to the professional village. In very few instances, for a couple of participants significant learning also emerged as they witnessed clients handling their needs and connecting with their own communities. For instance, Cortina and Peter provided examples of their own sense of development from learning about how their clients' handling of community resources to meet their needs.

> CORTINA – [the client's mother] helped me understand, well swimming is what helps her [child] focus because it gives her physical sensory input and she's on this medication.

She expanded my knowledge about community resources. She really helped me learn

well if I see another child with this similar disorder, I could provide those ideas like

swimming or medication or connect her with that mom to get more research so that's an

example that comes to mind.

PETER - Learning from the clients, patients themselves, learning from them, you learn

about their disabilities from them, you learn about their needs from them. Sometimes

they're the best source of information and training.

Additionally, during the second round of interviews, it was evident that the property of

clients and families narratives was analytically related to the need to capture the client's needs

and create a space for the *client to lead* the goals of treatment based on their current mental

health demands. The dimension of *client's lead* has been situated within the additional analytic

factor ***counseling focus***, which was also integrated into the theme of **The Therapeutic Work**

earlier in the analysis. Cortina offered an example of her need to establish an egalitarian space to

learn from the client's narratives and foster the client's expression of needs.

CORTINA - I have a very egalitarian viewpoint [for the client to describe their needs]

that I am here to facilitate and to learn from you. I feel even more so with this population

that I learn so much more from them because they're living this. They're coping with this

on a daily basis so they have so much more to teach me. The element of learning from the

client feels so much more prevalent in this situation in my building of competence.

Also noteworthy was how the participants dimensionalized the outside village by naming

their interactions with the ***client's community***. For instance, Henry confirmed the significance of

understanding the client's level of involvement with their own community when assessing

availability of services and support. Specifically, Henry named the example of the clients' access to spiritual support through connection to their own community.

> HENRY - Those were like, those were things that we're already kinda set up, not set up by the client, but by the client's family is already connected. Those things I think contribute to the client's well-being, very advanced way to help them reconnect to a greater, not even a greater community as a whole, but like other aspects to the life that I would not be able to help with. But that still will help decrease depression, help the person feel connected, and help the person feel loved. So I think that's always been a very good thing, but usually when I work with the client they've already been connected, and I wouldn't really have that too many time to talk about additional spiritual services. I would have a discussion about it if the client wasn't connected, and sometimes we've done exploring with clients about that, but it's basically usually the client have already been connected to community organization, church and they've already been connected with their family.

In summary, in the second round of interviews, the participants named the disconnection from the client's community and the majority of counselors expressed the lack of experience in intentionally initiating contact with the community of people with disabilities. In the instances where participants had initiated this contact, they documented a variety of lessons learned, such as, first account advocacy, challenge to expertise, family resiliency and advocacy, as well as the power of peer support. Therefore, participants overall commented on the importance of collaborative work as counselors who serve this population. They also described the limitations when contacting the client's communities that would potentially enhance the counselors' perceptions of their development of competence. The following section illustrates the

participants' expansions pertaining to the theme **Evolving Commitments**, specifically the integration of an additional analytic factor to this category.

Evolving Commitments

During the second round of interviews, the participants confirmed their **Evolving Commitments** embedded in the professional role of a professional counselor and towards the population of clients with disabilities. Participants described how these commitments have progressed over time and have represented the potential to disrupt ***negative attitudes*** that pertain to lack of competence and experience in working with disabilities. Moreover, in order to move passed fear and other initial reactions when striving for competence, the participants highlighted how their ***self-initiation*** has increased. This self-initiation was framed in terms of seeking out information, consultation, and support. Iris' excerpt captures the importance it has had for her to recognize these reactions and move past them by self-initiating for more knowledge and consultation.

> IRIS - Recognizing when you feel comfortable and addressing that. Getting ... I don't know, I've always ... If I feel that way it's usually because I need, I just want some more information. Do some research on this kind of disability or this kind of mental health diagnosis and just get a little more familiarity with it. And then at the bottom line, the client is a person, a human being, no matter what they've got.

Even though the category ***sense of purpose*** was not prominent during the second round of interviews, the majority of the participants confirmed the importance of acknowledging their reactions and the reasons behind negative attitudes through personal work. The participants corroborated the need to engage in personal work aimed at embracing personal and professional struggles, facing assumptions, recognizing privilege, and disrupting the discomfort and

avoidance that might emerge from biases held by the counselor. Thus, all participants described their evolving reflexivity and awareness cultivation of these personal reactions. Eliza's and Kara's excerpts highlight their own engagement in reflexivity and the realization of their privilege in the counseling room.

ELIZA - I think it all depends on someone's self awareness to know how an able-bodied person does interact with a client with a disability. That definitely is extremely important, but nevertheless in my sessions, I think is just to be exceptionally mindful and present in the moment to be able to know that. Make sure you're asking questions that are respectful of the client that you're working with in that moment. I think many times I consider myself extremely fortunate based on the clients that I have had the privilege to work with and those that I see in the community ... people that may be suffering from a disability or challenged and impacted by one. For me, it goes down to being extremely aware of who you are as a person and how you affect someone.

KARA - It's very humbling yet discouraging at the same time. When you have that type of situation, I'll have clients where I'm like, "Oh yeah, look it up online." And they don't have a computer at home. Or situations like that just make me realize, what you said, how privileged I am. And it makes me feel bad, all the obstacles that they have to face.

Additionally, during the second round of interviews, it was clear that the participants' support of reflexivity for meaningful professional practice was strongly linked to the sub-category of *consciousness* in the existing theme **Competence,** as well as to the awareness of one's reactions and privilege in the additional analytic factors *ethical decision making process* and *understanding and using privilege*. The participants extended these descriptions to integrate

dimensions of advocacy as a result of the cultivation of consciousness. The analytic factor of *understanding and using privilege* will be added to the theme **Competence** later in this analysis.

In summary, the participants dimensionalized the category of **Evolving Commitments** to further integrate the factors informing the transition from negative attitudes to self-initiation, then to sense of purpose. Specifically, the participants added the dimension of *ethical decision making* in the treatment decisions when working with clients with disabilities. As described earlier in this chapter, the participants mentioned a variety of domains within their ethical decision making process that pertained to the boundaries of their competence, their cultivation of awareness, their ability to self-initiate to seek consultation, the availability of village resources, and the ability to craft meaningful recommendations for services when referring out. According to the participants, these domains guided their decision making process and informed their exposure to clients with disabilities. The following section illustrates the participants' description related to **Competence**, as well as the integration of an additional analytic factor to this category.

Competence

As the other categories became more refined according to the participants' descriptions of their experiences, so did the category of **Competence**. During the second round of interviews, the participants indirectly established the property of *disability as a cultural group* when describing their understanding of the disabled community's capacity for organization, identity, and advocacy. Moreover, the participants recalled the ways in which counselors have made contact with the *client's community*. Lynn provided an example of her involvement with an organization within the disabled community, by people with disabilities, for people with disabilities.

LYNN - So, for example, in [name of city], I worked with a few different clients who had

multiple, actual ... Disabilities actually. But, specifically in terms of their peer

community, they were engaged in [name of group], which is a peer support community

for peers, run by peers, with chronic mental illness. And, one of my clients was like very

involved in leadership of that organization, and through her I met ... You know, not like

her introducing me but her suggesting that I go to like, you know, these different things.

And basically what they are is community workshops put on by peers. And it was such an

incredible chance to learn and also to get like a sort of a deeper perspective of how that

community was organizing themselves.

During the second round of interviews, the participants offered further descriptions that

helped me refine and dimensionalize the property of *consciousness* within **Competence**. The

participants described how their commitment for reflexivity that fostered *sense of purpose*, as

described in the theme **Evolving Commitments**, also fostered the cultivation of consciousness

through their *understanding and responsibly using of privilege*. This was perhaps one of the

most substantial category amplification within the emerging analysis inasmuch as it was clear

that the participants situated reflexivity as the facilitator for the gaining of awareness about one's

positionality. *Understanding and using of privilege* has been integrated as an additional analytic

factor in the emerging analysis. Within this analytic factor, the participants extended these

descriptions to integrate dimensions of increased empathy, alliance building, and advocacy as a

result of the cultivation of consciousness.

Furthermore, the participants reflected on the progress on their ability to establish

collaborative relationships that represented *interrelated work* when serving clients with

disabilities. Peter commented on the increasingly interrelated work as a mental health counselor.

PETER - I may try to get somebody to a one stop shop like a New York State Office of

Mental Health PROS [Personalized Recovery Oriented Services] Program, where they

can get case management services. They can get planning to work, or what we used to

call IPRT [Intensive Psychiatric Rehabilitation Treatment] Services, service coordination,

therapy and the whole thing in one, sort of one shop. I try to refer somebody to a program

like that, so that they have everything at the program and I don't have to keep pulling all

the smaller pieces. In my role here, I have so many functions. I do supportive therapy and

supportive counseling, and I do academic counseling. I do vocational counseling. I'm

working with different players like AccessVR [New York Adult Career and Continuing

Education Services-Vocational Rehabilitation], OPWDD [New York Office for People

with Developmental Disabilities] and I try as much as I can to work with an advocacy

group to advocate for the disabled and help them to get services with OPWDD and

AccessVR.

During the second round of interviews, it was clear that the participants' connection with their

professional communities, their ability to *self-initiate* to obtain further education, consultation,

and support, and the achievement of clinical practice through *interrelated work* were

intertwined.

Moreover, the participants refined the property *dimensions of oppression* within

Competence by highlighting the need for *understanding and using privilege* in a way that

fostered the disruption of these oppressive dynamics through advocacy. It was clear that these

two categories reflected a potentialized interpretive power when counselors used their power and

privilege in the system to disrupt these *dimensions of oppression*. Iris provided an example of

her utilization of power as a mental health counselor in the system.

IRIS - Another example is more with this clinic within the clinical but school based, was going to a committee on special education meetings. I have been to quite a, not a lot, for the most part we work well in the education system, but I've been to quite a few key meetings for kids. But if the school wants to kick them out, you're out. Before going to the meeting, I sat ... I remember sitting next to a Vice Principal and said here's what we're recommending. Okay, this is what we're going to do, okay. Life we're getting a clue. Like lettering me know. I said no, here's what I'm recommending and its something completely different. She didn't like it. Didn't like it. So they wanted to kick the kid out because he had had, he was young and, I don't know if it was a psychotic break but that's what it looked like, and he was a good kid and well behaved and had about a month of pretty big problems, then that treatment medication was functioning beautifully. They wanted him out and we advocated that that was not right, that he was actually doing very well in that school and he stayed at that school and graduated.

In summary, the participants dimensionalized the category of **Competence** by integrating the analytic factor ***understanding and using privilege***, as well as linking it to other categories within the existing analysis. This dimensionalization and linkage to other aspects of the analysis increases its interpretive power and enhances the theorization of the counselors' perceptions of their development of competence to work with clients with disabilities. The following section illustrates the participants' descriptions related to the category **Systemic Dimensions**, as well as its connection to emerging analytic factors.

Systemic Dimensions

During the second round of interviews, the category **Systemic Dimensions** continued to evolve and extend to other parts of the analysis based on the participants descriptions of their

experiences. During the second round of analysis, it became apparent that the property ***double bind*** was solidified in the participants' descriptions. Specifically, the participants commented on the multiple ways in which their clients are left with no answers and less possibilities for initiative even when engaged in the mental health system, which further penalizes them if they disengage.

Moreover, congruent with the additional analytic factor ***understanding and using privilege***, the participants expressed increased awareness of how the system fails the client while cornering them into a double bind dynamic that significantly limits their opportunities for wellness and resiliency. Kara provided an example of how one of her clients is systematically failed by the system as well as her efforts to advocate for this client's needs.

> KARA - So I look on the thing and I'm like, "He doesn't have active Medicaid." I feel like the system's setting him up for failure. And everything that ... you know, for me that would be just so easy to solve these issues. It's just more and more obstacles and then I think, too, I have a Masters Degree in this stuff and I'm sober and I still find it very challenging. How is the system setting this guy up for failure. Just play the tape through. It's like, okay so he doesn't have insurance so, even though my agency is kind of like, "Okay, we'll keep going assuming he will get Medicaid." Which a lot of other agencies wouldn't do. Now he ... I can't set him up for the Medicaid taxi. I can't get him introduced onto the Suboxone. He can't go pick up his mental health meds that are waiting at the pharmacy. And pretty soon the Department of Social Services is gonna sanction him for not making all of his appointments, but how can he make all of his appointments when he doesn't have enough medications or treatment. Oh and then when all that plays out, he'll lose his homeless shelter. It's situations like that the system is failing him. And I don't

know what to do about it. And I talked to my supervisor and she doesn't really know. So I

called care coordination, because everyone at this point is telling me ... I talked to DSS,

doing that whole coordination of care thing and everyone's like, "The only thing you

could do is drive him down to the Department of Social Services." Which of course is

inappropriate in my role, so I want to set him up for a care coordinator and case manager.

And they're like, "Well we only accept people on Medicaid." So I gotta find a division for

somebody that accepts people that don't have Medicaid. That are uninsured, or whatever

you want to call it. And at this point he needs to go inpatient. And this is somebody that if

he doesn't get insurance soon ... at this point I'm trying to get him to come in on Tuesday

and I'll refer him to a rehab where you don't need insurance, they'll take anybody. But the

waiting list is cold when it's this cold out too. To me it's like a life or death situation. He

is shooting heroin. This is crazy.

Even though during the second round of interviews the properties of ***silencing of***

disability and ***prejudice and stigma*** did not significantly emerge in the participants' descriptions,

the property of ***productivity in mental health systems*** was significantly reflected upon by the

participants. Specifically, the participants described their experiences in mental health systems

that required them to demonstrate client change through consistent documentation, treatment

planning, and observable outcomes. The participants actively situated these demands within the

system's fantasies of cure that demand client's achievement of treatment goals as indicative of

mental health improvement. The dimension of *system's fantasies of cure* is described within the

additional analytic factor ***counseling focus***. Natalie emphasized the need to let the client lead the

course of treatment as well as refrain from narratives that indicate the counselor controls the

course of treatment.

NATALIE - I feel like we shouldn't have the specific goal of what we think we need to help the patient do. We are going to make them be their best selves. [When overly emphasizing treatment plans and observable outcomes] it almost sounds like playing God in a way and being like "I'm going to help them do this or that. This is my role."

In summary, the category **Systemic Dimensions** continued to emerge as the participants situated some of its properties into the emerging analytic factors ***understanding and using privilege*** and ***counseling focus***. Moreover, as counselors' **Evolving Commitments** afforded them opportunities for increased awareness of their own privilege, they demonstrated heightened intentionality for disrupting systemic dynamics that further oppress the clients. The following section presents a diagram of the emerging grounded theory of counselors' perceptions of their development of competence to work with clients with disabilities and further synthesizes the integration of the four additional analytic factors within the emerging analysis.

Emergent Grounded Theory Integration after Second Round of Interviews

The second round of interviews afforded the participants the opportunity to expand their descriptions and enhance the interpretive power of the emerging analysis by establishing meaningful connections between the existing and new analytic components. The second round of interviews provided richness from confirming existing categories and expanding their properties to other parts of the analysis. Next, I present a theoretical integration of the additional analytic factors identified in the second round of interviews and deconstruct the new analytic components encapsulated in the counselors' perceived development of competence to work with clients with disabilities, as it is depicted in Figure 16. Thus, by using the theoretical sequence proposed in this analytic diagram, I work to illuminate the additions to the emerging theory based on the recently identified analytic factors. Therefore, the Figure 10 from Chapter V has been modified

to reflect the change of the participants' descriptions and better explain the counselors'

perceptions of their development of competence to work with clients with disabilities.
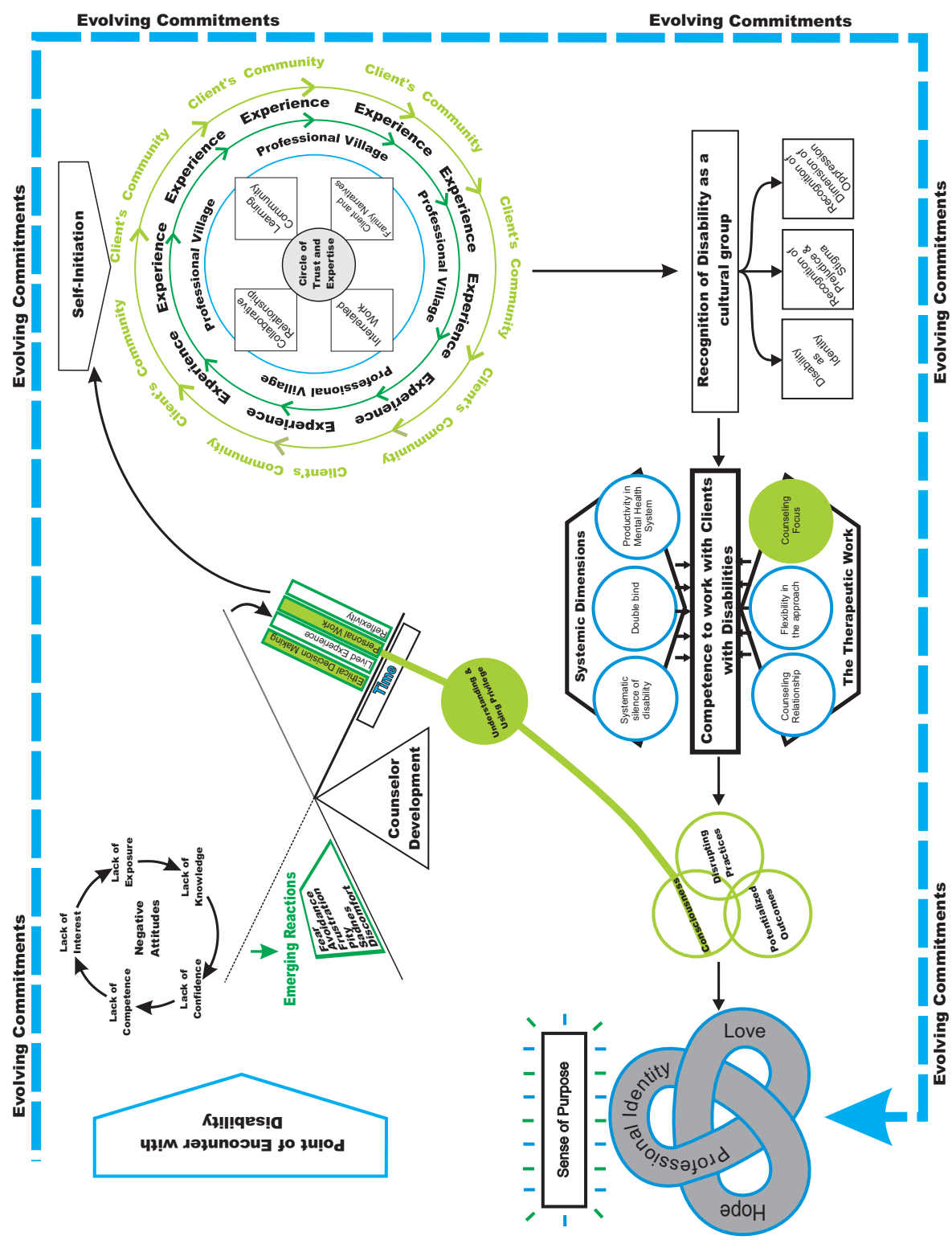
Figure 16. Emergent Grounded Theory Integration After Second Round of Analysis

As previously described, the second round of interviews led to the identification of four additional analytic factors: ***ethical decision making***, ***client's community***, ***understanding and using privilege***, and ***counseling focus***. These emerging analytic factors were recognized, substantiated, and integrated within the existing categories encapsulated in the emerging theory of the counselors' perceptions of their development of competence to work with clients with disabilities. In this chapter, these emerging analytic factors were further interwoven across the existing analysis as it made sense for the participants.

As depicted in Figure 16, the first emerging analytic factor, ***ethical decision making***, served an additional mediating factor between ***negative attitudes*** and ***self-initiation***. Specifically, the participants described how their own navigation of the ***ethical decision making*** process led to the reflection of commitments for reflexivity of one's reactions, self-initiation for further education, consultation and support, as well as for the initiation of sensitive and meaningful conversations with clients and families regarding treatment decisions. The commitment for reflexivity and the cultivation of self-awareness about one's reactions and biases perhaps was one of the categories the participants most reflected upon. Therefore, the analytic factor of ***ethical decision making*** process further complemented and reinforced the previously identified factors of ***lived experience***, ***personal work***, and ***reflexivity*** that informed counselor's development and self-initiation.

An additional analytic factor that emerged from the second round of interviews, ***client's community***, further dimensionalized the components of the "village," and highlighted the potentially reciprocal relationship between the counselors' professional community and the community of people with disabilities. Specifically, the participants stressed their experienced disconnection between their professional community and the organizations and support groups

by people with disabilities for people with disabilities. In the cases where participants had been in contact with these communities, they identified several lessons learned that mainly pertained to the power of first account advocacy, families' resiliency, and peer support. The addition of this analytic factor further highlights spaces of opportunity within the "village" for inclusion, outreach, and a more comprehensive sense of community. Moreover, participants acknowledged that the intentional and consistent connection with the client's community potentializes the perceptions of their development of competence to work with this population. Across the connection to the *client's communities* and counselors' engagement in *collaborative relationships*, *learning communities*, *interrelated work*, and *clients and families narratives* through *experience*, the participants demonstrated a heightened recognition of *disability as a cultural group* and enhanced **Competence.**

Another analytic factor that emerged from the second round of interviews, *counseling focus*, was situated within the counselors' expression of **Competence** in **The Therapeutic Work** in Figure 16. Specifically, this analytic factor synthesized the **Systemic Dimensions** reflected through *system's fantasies of cure*, *double bind*, and *demands for productivity*, and the *counselors' intentionality to embrace difference* through the *counseling relationship* and the *flexibility in their approach*. All the participants emphasized their intention to engage in meaningful, affirmative, and productive counseling work that represented emotional relief and wellness for clients, based on their experienced needs. Moreover, the analytic factor *counseling focus* further confirms the adjustment of dichotomous language (*becoming vs. overcoming*), previously stated in Figure 10. The participants' descriptions illuminated the expression of competent counseling practice through the domains of *consciousness*, *disrupting practices*, and *potentialized outcomes*.

The final analytic factor identified during the second round of interviews was counselors' ***understanding and use of privilege***. The addition of this analytic factor not only confirms the property of ***consciousness*** within **Competence** and dimensionalizes the extent of ***disrupting practices*** to include becoming and ally and advocacy/self-advocacy. Rather, the addition of this analytic factor also highlights the theoretical connection to earlier mediator of counselor development related to ***ethical decision making***, ***personal work***, and ***reflexivity***. The participants emphasized the importance of realizing and using the counselor's positionality within the system for advocacy, client self-advocacy, and instillation of hope, which altogether inform the increased ***sense of purpose*** as licensed professional counselors working with clients with disabilities. Moreover, the updated version of participants' perceptions of their development of competence to work with clients with disabilities described in Figure 16 was reflective of counselors' **Evolving Commitments** through clinical practice.

At the conclusion of the second round of analysis, a more refined version of the emergent grounded theory was identified to describe the participants' experiences with the phenomenon. Figure 16 illustrates existing and additional categories and properties that explain the underlying dynamics related to the participants' interaction with the phenomenon. The second round of interpretive dialogue interviews further clarified the emerging analysis for a deeper and established understanding of these dynamics that inform the theorization of counselors' perceptions of their development of competence to work with clients with disabilities.

Interpretive Dialogue Process

The second round of interviews afforded meaningful confirmations and expansions of the existing themes and properties from the first round of data analysis. The second round of interviews also provided a more comprehensive description of the participants' perceptions of

their development of competence to work with clients with disabilities. The next and final step in the collection of data was to conduct member checks in the form of a second interpretive dialogue interview with each participant. During these interviews, I presented the participants the emergent grounded theory of their perceived development of competence to work with clients with disabilities. Each participant then had a new opportunity to adjust, expand, confirm, and disconfirm the emerging analysis based on their experiences of the phenomenon (Clarke, 2005).

As mentioned before, through the engagement of my participants in interpretive dialogue interviews, I honored the collaborative and co-constructed nature of my research design and strived for openness and intellectual curiosity of their experiences. As I prepared for the second interpretive dialogue interviews, I constructed a document containing the emerging grounded theory with the additional analytic factors that resulted from the second round of interviews. In preparation for the second interpretive dialogue interviews, I actively engaged in peer debriefing with my research team in order to collaboratively refine the emerging themes and properties to be presented to the participants.

Consistently with the first interpretive dialogue interviews, I sent this document in advance to my participants for their review prior to engaging in the second interpretive dialogue interview. This emerging and integrative analysis document can be found in Appendix I. Also, the interpretive dialogue interview questions were grounded in the participant's impressions and reactions to the emerging grounded theory about their perceived development of competence to work with clients with disabilities. I actively worked to capture the participants' feedback to the proposed analysis and aimed to co-construct further descriptions that would expand, adjust, or confirm the emerging grounded theory. Additionally, my sustained intention

for the exploration of participants' reactions also included the attention to their suggestions that would increase the fitness and resonance of the proposed diagram.

Chapter VII: Second Interpretive Dialogue

Introduction

The second round of interpretive dialogue interviews took place two weeks after the second round of interviews. As with the first interpretive dialogue interviews, I prepared and sent to my participants a document containing the emerging analysis with the written and graphic descriptions of the categories, properties, and sequences that had been previously confirmed and debriefed with my research team. Please see Appendix I for this document. Specifically, this document provided an integrative overview of the analysis that included the categories identified during the first round of interviews and the integration of emerging analytic factors that led to a comprehensive explanation and representation of the emergent grounded theory. For these interviews, all twenty participants acknowledged receiving the document and reviewing it in advance.

The main purpose of the interpretive dialogue interviews was to capture the participants' reactions when presented with the emergent grounded theory that had been co-constructed through the research process. Thus, my intention as a researcher was to document the participants' confirmations, expansions, and further elaborations of their experiences in developing their competence to work with clients with disabilities. Moreover, given that in this document each category and property was also substantiated with the excerpts from different participants, the participants had the possibility to know other people's experiences with the phenomenon and further enhance the significance of their descriptions.

I initiated each of these interviews by naming the main categories I identified in the first round of interviews. I then highlighted additional analytic factors, and asked the participants about their level of resonance with the categories, properties, and processes represented in the

emergent theory summary and diagram (Figure 16). Similar to the first interpretive dialogue interviews, when presenting the diagram illustrative of the emergent grounded theory, I worked to position this representation as a version resulting from my particular cultural and professional lenses, and encouraged the participants to further challenge and refine this depiction based on their own positionality. Moreover, I encouraged the participants to express their views about how my conceptualizations aligned (or not) with their experiences. With this, my hope was to preserve space for a shared construction of knowledge and enhance the interpretive power of my analysis.

The participants expressed resonance with the emergent grounded theory I presented in the second interpretive dialogue interview. Additionally, participants confirmed the categories, properties, and sequencing of constructs represented in the analysis. The following section illustrates the participants' reactions and confirmation of the emerging analysis proposed and includes participants' excerpts from the second interpretive dialogue interviews Specifically, this section illuminates further elaborations and examples provided by the participants.

Second Interpretive Dialogue Analysis

In the second interpretive dialogue interviews, I intended to open the conversations with my participants by exploring their initial reactions to the emerging analysis as a whole. Specifically, it was my intention to capture their comments of how this emerging grounded theory fit their experiences of their perception of how they developed competence to work with clients with disabilities. I proceeded in the same manner with all the participants.

Moreover, I consistently engaged in strategies that guaranteed trustworthiness of the findings and the emerging analysis. Specifically, throughout the data collection process, I systematically remained immersed in the data, peer debriefed, memoed, triangulated, and

continued reflexive discussions and documentation. These methodical strategies facilitated the co-construction of the understanding and description of the participants' perceptions of their development of competence to work with clients with disabilities. In the next section, I will work to demonstrate how the participants confirmed and expanded the analysis' established categories and properties.

The Therapeutic Work

The majority of the participants confirmed the importance of recognizing ***disability as an identity*** with unclear boundaries. Throughout the research process, participants consistently reflected on the boundaries of disabling mental health conditions and expanded their conceptualization of who is disabled and not. In the second interpretive dialogue, the participants continued to reflect on the definition of these boundaries and asserted that disability as an identity also has many sub-groups within it. Allison's excerpts demonstrate some of these reflections.

> ALLISON - I always want to think about are people with disabilities, are they the same as somebody who has bipolar disorder? How different are they? And I circle with that because sometimes it's just not so different, you know? And I think maybe that is why, now that I'm thinking about these things, maybe that's why we don't have a course on it, because it's really all the same.

Thus, Allison stressed the importance of recognizing the complexity of disability as a construct and the uniqueness of the experiences of people with disabilities. Other participants further situated this work in the potential of the ***counseling relationship*** with these clients.

GLORIA - And then it's also I think going back to...you know they say that it doesn't matter what kind of therapy you use, doesn't matter what you know. It's all about that therapeutic bond. You know, that relationship, that rapport, that connection.

Thus, during the discussion of the analysis, the participants consistently corroborated the importance of the connection with the client through the ***counseling relationship*** in order to understand what the client's expectations and needs are from the counseling service. Also, the participants emphasized the need to connect with the clients for the counselor to articulate their resources and ***tailor the approach*** to best meet the client's needs. In this sense, some participants corroborated the relevance of remaining flexible, open, curious, and creative in the work with clients with disabilities. For instance, for Sarah, this was one of the parts of the analysis that significantly captured her attention in the whole diagram and that connected to the counselor **self-initiation** for collaboration and learning. Moreover, Tela described the use of flexible approaches for the work with clients and provided an example of the use of bibliotherapy.

SARAH - And the second piece was flexibility. One of the reasons flexibility really resonated with me ... Because I think as counselors, we're trained, you know, you do this model or you do this theory, and that's what has to work. But having the flexibility of being able to say, "you know what, I don't know too much about this disability, let me spark some interest, let me get some feedback from other people, let me get a training ...", and having that flexibility and that openness to be able to say to somebody, you know in your field. "Listen, I don't have a lot of knowledge in this, or confidence in this area, but I am committed to making a positive impact on this particular patient, what do I do?". So that's really what resonated with me.

TELA - I think that bibliotherapy has been shown in a lot of research to be as effective as therapy. I think that a lot of people whether they give that direction through seeing a therapist or just on their own, for patients it's great and also for counselors, professional development kind of goes into each of those. Like if I or anyone else needs to learn about a new approach or trying to build competence, we might go to a training but we're more likely to read a book on it depending on our location and those kinds of things. And also I think for patients, bibliotherapy can be just hugely helpful and have a large impact.

Participants further supported and confirmed the analytic factor of ***counseling focus*** within **The Therapeutic Work**, in substitution of the previous category of ***becoming vs. overcoming***. Specifically, the participants appreciated how the analysis captured and represented the fluid and dynamic nature of their counseling work without falling into dichotomous thinking. Participants confirmed how counselors navigate systemic factors that convey the system's *fantasies of cure*, while also enacting their own *intentionality to embrace difference* in the counseling room and to tailor their approach based of the client's expressed needs and goals. Thus, Lynn and Faith suggested adding fluidity to the counseling intervention targets in **The Therapeutic Work**. Moreover, DDD confirmed this analytic factor to be a representation of her professional navigation of treatment goals and objectives based on the client's lead.

LYNN - So I think that it makes a lot of sense. I think that the complexity that you're capturing there is important. I think that the one word that stood out to me in terms of the right side of the diagram, under descriptors, you had "client metrics of progress". I think that that's just an interesting point in general because I think that that word progress might still reflect a little bit too much of the systemic want. Because I don't know that every client would describe their process as being oriented towards progress, more than

well-being or things that aren't necessarily always moving in a forward direction. So I thought that in general you did a really good job of capturing all the things that make that focus complicated and that make it a moving target, and that make it really fluid to not one static thing. And I think that given all of those considerations though you ... I think that this is a strong illustration of that. I think that there are just some concepts that are more easy to represent and I think that, especially when you're combining a graphic element with words, you're trying to make those things say different things in the sense that you want them to add context and complexity but you want them to all speak together. So I think that this definitely does. I think it's the one thing that gave me something to think about on the systems fantasy of care side of it.

FAITH - I think it's the infinity sign, I think that is the best way to go through and to describe it, because I think it does fluctuate back and forth between what we're trying to do. Do you know what I mean? Going back and for the between the two things. I don't think it ever would be a straight line thing. I don't think it ever could be a straight line thing, because I think we're always evolving changing. You know what I mean? And when we think we've made progress or something else that comes a long, so that swings us back around again. I think it's just always the way it's going to flow like that.

DDD - Yeah, I mean I really liked this aspect of it because I think it's really kind of ... I guess it attunes to some of the changes in the healthcare field currently. So, typically we think about objective goals, typically I have thought about objective goal is get that job or reduce this number of symptoms or something like that, and it's been an evolution for me to think about goal-setting, and quote-unquote overcoming in a different way that doesn't necessarily mean curing the disability or stopping certain things and more-so helping the

client just understand it and decide what they want. And that's a different process for me. But to be able to name it and work toward some goals that while they're still objective, are a little bit different than what I originally envisioned overcoming or objective goals to be.

Additionally, within the additional analytic component of ***counseling focus***, participants corroborated the importance of crafting their counseling approach based on the client's lead. Specifically, participants highlighted the importance of defining a counseling focus that honors the client's expressed goals but that also acknowledges the larger systemic demands of the counseling work. Unice's excerpt below illustrates her confirmation of this analytic component within the analysis.

> UNICE - I think that again, it's very crucial, it's important. It is a struggle sometimes because again, we're there for the client so what their identified goals are, are very important and sometimes other things emerge throughout the course. So, I think it's very important for us to stay focused and aware on the kind of needs but also what our observations are. It's a very sensitive situation but it's part of our role to just inform the client what some of the observations are, review the goals and make sure that that's implemented appropriately for the benefit of the client.

Overall, the participants confirmed the importance and accuracy of the category **The Therapeutic Work**. Participants corroborated how this category has evolved for them as they have clarified disability as an identity, grounded their role in the counseling relationship, and tailored their approach and counseling focus based on the client's lead. Moreover, the participants acknowledged the importance of this category in their perceived development of competence to work with clients with disabilities. The next category examined within the

interpretive dialogue interviews related to the counselor and client's surrounding community and their opportunities for collaboration and support.

"It Takes a Village"

In general, participants consistently confirmed the importance of the professional and client's community as part of the "village" conceptualized within the emerging analysis. During these interviews, the participants also highlighted the multilayered representation of the village and positively evaluated this depiction in the integrative analysis. Specifically, participants confirmed the importance of ***collaborative relationships*** with supervisors, peers, and other mental health professionals in the professional community. For instance, Henry and Sarah emphasized the need for supportive and consistent professional collaborations in the work as professional counselors working with clients with disabilities. Also, Maria confirmed the beneficial nature of considering and integrating other colleagues' perspectives in order to improve the work as professional counselors.

> HENRY - Well the way I interpret professional village is ... I interpret that as good co-workers, good supervision, and good people to ... I'm trying to think when someone is the consultation, yes. That's what I'm thinking of, good consultation. So yes, I think profession-ability is a good word for that. Because it may not necessarily be someone that is on your staff but someone that is still available to you. And also, people do come in that will give presentations to your company, and stuff like that. I would consider that to be a part of the professionalism as well.

> SARA - Or we as professionals remain in a bubble because we just don't, we don't operate like that you know, human beings, we need those connections with other people,

as do our clients. So the idea of, it takes a village is just a resonating for me as a clinician as it would be for treating a client.

MARIA - But it really breaks, it's confusing when you first look at it but I love it. Because it really gives you a good perspective of how, you always talk about the professional village, which I love. We can have a private practice and do what we want to do on our own. But I always think that I learn better working with other people, and getting other people's perspectives. I do think it's the professional village of our co-workers, as well as our clients. Because they know stuff that we don't know.

Additionally, participants confirmed how ***learning communities*** are part of the village and represent a space for counselor self-initiation and learning. This property was further dimensionalized during the interpretive dialogue interviews. Tela not only confirmed the importance of the professional village but also expanded her descriptions to include the power of social media for professional consultation about services and resources for clients.

TELA - When I moved to [name of state] three years ago and was kind of just learning about some resources here because I'm a substance abuse counselor and mental health counselor, but I am learning about the substance abuse resources here and what's the culture. One of the first things I did was go in some chat rooms or try and educate myself around what's going on in this area. Then also I joined some larger AA style forums to understand the resources, what's available, are they things I want to recommend to patients or not. Just kind of get familiar just for my own clinical understanding of the culture and what's going on as far as that dynamic. Also, what resources are available through testing them out in that social media kind of platform where you can be pretty anonymous and curious about the culture in general.

Along with the confirmations of the *learning communities*, the participants also corroborated the importance of attending and learning from the *clients and families narratives*. Even though this property is intrinsically linked to the previous idea of following the client's lead in defining the *counseling focus*, participants further confirmed the importance of recognizing and learning from the uniqueness of experiences the clients go through in their social world. For instance, Gloria confirmed and exemplified this by commenting on how even having extensive experience with persons with disabilities in other professions (i.e., Special Education), as a counselor, she still recognizes the need to learn about the uniqueness and potential of each of her clients.

> GLORIA - The client is the...nobody knows what it's like to walk in their shoes. And you know I was also thinking like, you know we could spend as much time as we want learning about a particular disability, like I could be an expert in Asperger's. And somebody could be an expert in substance abuse, or whatever it is. But that doesn't mean that you really understand it, because that's just a small part of...the bigger picture is how that disability interacts with that family, and then with that community. So I think the most interesting part of that is no matter how...I mean I can't even count the many special needs students I've encountered throughout my career, and my life and my work now. But, none of that experience has fully prepared me to work for the person sitting next to me. It just almost makes me in tuned to the fact that this is another individual that's bringing in the unique set of circumstances that I have to learn about.

Gloria's excerpt illustrates the recognition of disability as something that cannot be reduced to singular or monolithic descriptions of identity, that is impacted by cultural markers of race, class,

gender, etc., and which takes each person to experience it in a unique way. Gloria's excerpt further recognizes disability as construct that is complex.

The addition of the analytic factor *client's community* into the category **"It Takes a Village"** was further corroborated and supported by the participants. For instance, participants highlighted the importance of recognizing and consistently integrating the particularities of the client's community into the work as counselors, as well as actively initiating the contact with these communities to gain a sense of the resources available for clients. These descriptions move the focus from service providers to individuals with disabilities as sources of expertise and knowledge. Queen and Unice's excerpts below provide a description of this.

> QUEEN - I think it's really important to have client's community in there, because that's something that just for myself, I'm aware that I'm not always conscious of that. I think it's an important piece, thinking about somebody who's in their training program, and they're starting to do work in this area, to be able to really reflect on where someone might not necessarily think of client's community as the parent and whomever. They may only think of it as, "This is a person who's deaf," and what deaf community looks like, and how different they might look at it more of the sociological aspect of it. I think being able to attend to all of those things is really important, so I think in terms of having that separately identified, I think that's really important. I think that's great.
>
> UNICE - I think the one that stood out for me the most was the client's community, again because in my experience, that's such a crucial part. There's so many different layers that depending on where my client is from it might not be from my immediate community that I am so familiar with and so connected to. The importance of either the connection or the disconnection of the client's community, to me, it's such a vital piece because

sometimes the client comes in with the expectation that we have this knowledge at our disposal and sometimes we don't. And sometimes we have to go and do the extra research and introduce ourselves and find out what does exist so I think that's such a crucial part that sometimes I feel, again, it all depends on everybody's experience but to me, it has become such a crucial piece in working with my clients.

In summary, the participants corroborated the collaborative and community-oriented nature of the counseling work with clients with disabilities through the category **"It Takes a Village."** Participants emphasized the importance of close networks of support through *collaborative relationships* that represented *learning communities* for counselors, and that further prepared them to attend to their *clients and families narratives*. Moreover, participants confirmed the integration of the *client's own community* as an important factor when developing competence to work with clients with disabilities. Specifically, the participants highlighted the importance of peer professional support as well as disabled communities as direct sources of knowledge, support, and expertise for counselors learning to work with clients with disabilities. The next category discussed with the participants during the interpretive dialogue interviews was **Evolving Commitments**. When discussing this category, the participants also corroborated its resonance with their perceptions of development of competence to work with clients with disabilities.

Evolving Commitments

Overall, during the second interpretive dialogue interviews, the participants confirmed the presence of **Evolving Commitments** in their perceived development of competence to work with clients with disabilities. In general, the participants confirmed their preference for the use of the word "commitments" instead of "compromises" to describe the multiple factors that inform

their intrinsic motivation to develop and reach sense of purpose in their work as counselors. Cortina, Faith, and Henry's excerpts illustrate some of the comments supporting this change.

> CORTINA - Because commitment is more, I guess for me. Like I said: it's a loyalty. A sense of commitment feels like a grounding principle. That keeps someone motivated toward competence. So they have committed to the feel that: "I'm committed to this population, so I will engage in the aspect." And it feels more of a positive. The word "commitment". While the word "compromise" just feels more ... A little bit negative, maybe? Or, a little bit, like: "I have to give up something." And, yeah, so I like commitment more.

> FAITH - No, I think commitments is, I think it's the right way to describe it. That's what we have to do. We have to make a commitment for that. I wouldn't change anything. This is amazing.

> HENRY - Like I think commitment is a much better word. I think with commitment comes a willingness to learn. With compromise it kind of feels like both parties are giving something up. And I feel that I've never really given anything up working with my patients. And as much as I've become further developed because of that. So I think commitment is better.

The participants highly resonated with the presence of ***negative attitudes*** and their emerging reactions when beginning the work with clients with disabilities. Specifically, the participants confirmed that these ***negative attitudes*** and emerging reactions were situated at the initial stages of the development of competence. For instance, Eliza highlighted how these attitudes and reactions, when unresolved, held them back from developing competence to work with clients with disabilities. Also, Brittney and Natalie confirmed the presence of reactions to

clients with disabilities in connection with counselors' lack of interest, experience, knowledge,

confidence, and competence. Moreover, given these initial reactions, Henry and Jerome

confirmed the importance for counselors to move past these reactions through the cultivation of

awareness and consistent engagement in *reflexivity*. Lastly, Lynn confirmed the graphic

representation of this property within the diagram.

> ELIZA - That is a question and just kind of what that can be balanced by. Obviously this
>
> weight is really heavy, which is holding down that side, but this is the part that stuck out
>
> to me.
>
> BRITTNEY - Yeah. Even the Counselor Development section is very interesting, too.
>
> The fear, avoidance, frustration, pity, sadness, and discomfort is something you go
>
> through with every client. I have seen a lot in my agency. A lot of the discomfort, fear,
>
> and avoidance. Then you have the lack of interest, lack of exposure and all those negative
>
> attitudes and it only makes sense.
>
> NATALIE - I sort of think that's interesting because obviously we're humans as well.
>
> Sometimes we can forget that one things leads to the other. A lack of confidence, because
>
> we don't have confidence, can lead to avoiding working with certain clients. It's just sort
>
> of cool to see, to put those so close together because one leads to the other, when
>
> sometimes we forget. We work with our clients so much on keeping them on track to
>
> keep their thoughts and their emotions, one leads to the other and vice versa, so it's sort of
>
> cool to point that out about us as humans as well. We're the same. You know?
>
> HENRY - I talk about the negative attitudes, about the multiple negative attitudes that are
>
> there. And kind of the thing on forefront of that, the change we want to change as the
>
> person has more of the ability to get the experience and like more reflexivity.

JEROME - I think like anything with therapy or counseling it's so important to be self-aware, so I think you cannot say that a person wouldn't have any type of reaction. I think there's always a reaction regardless of who you meet. Yeah, I would totally agree with that.

LYNN - Okay the little seesaw, the little teeter totter that you have with the counselor development as the base and those emerging reactions and then the time, I thought that that was great way of symbolizing what that looks like. So I really liked that part of it a lot.

Additionally, in order to move past these emerging reactions, the participants confirmed the need for counselors to *self-initiate* and reach out to their professional and client's communities in order to gain consultation and learning. The confirmation of this property of *self-initiation* further links it to other parts of the analysis related the professional village and client's community. Reece's excerpt illustrates the need for counselors to self-initiate and reach the broader community for education and support.

REECE - sometimes when you first start working with the client you're not really sure what direction to go down and you just kinda have to gather your resources. And figure what you're gonna do to get the information, or whatever have you. And then you kind of formulate a plan.

As participants commented on their **Evolving Commitments** and development, they also confirmed the importance of *time* and *experience* in their perceived development of competence, and in order to become more confident and knowledgeable in the role of a counselor of clients with disabilities. For instance, Lynn confirmed how developing competence entails time and experience and looks different for beginning counselors.

LYNN - I think that for me, where I'm at now in my work that those [**Competence**'s dimensions] definitely capture it for me but I'm thinking about somebody who is just beginning in this work that something, an initial step towards competence is just really, really basic skills and so I think that that represents a growing level of competence, but I'm thinking about beginning counselors, a lot of it is like the nuts and bolts of counseling.

Ethical decision making was an additional factor encompassed in counselors' **Evolving Commitments**, and which assisted them in the process of moving beyond the initial *negative attitudes* in order to *self-initiate*. In general, the participants confirmed the importance of the *ethical decision making process* as an additional factor that enhances development and that grounds them in the commitments for *reflexivity* and *self-initiation* when working with clients with disabilities. For instance, Unice reflected on her ethical responsibilities to realistically acknowledge the boundaries of competence and operate from a framework that guarantees the best options available for the client.

UNICE - I think [the ethical decision making factor] is very important. I think that when we engage a client, that's one of the responsibilities that we have to go through in order to determine what the next steps are. What is it that the client is experiencing? Because unless we go through that initial process, it can be an obstacle for our moving forward if the client is not prepared or is fearful. Is there avoidance? Then sometimes, again we need to be honest with the client and with ourselves and how can we overcome some of these boundaries that we might be facing? So I think it's very important for us to initially begin that process just so that we can again, be able to better service the client so I'm glad

that that was brought in because again, it's very difficult to separate some of these factors.

They're so interconnected that we have to bring attention to it.

Lastly, the majority of the participants confirmed that the achievement of *sense of purpose* in the practice as a professional counselor working with clients with disabilities is a final step in their perceived development of competence. Specifically, participants strongly made meaning of their experiences in terms of the hope for a greater good in their communities and the genuine care for their clients. Faith described the emerging sense of purpose as her hope for humanity, whereas Jerome described it in terms of the ability to become "enlightened" through the engagement in *reflexivity*. Lynn expressed her resonance with the graphic description of this concept in the integrative diagram. Moreover, Natalie extended and confirmed the description of the sense of purpose, and highlighted the idea of love and hope as the main drivers for professional identity.

> FAITH - Then the sense of purpose, I like this that it's the final because at the end of the day circling back around to why we do what we do is our hope in humanity and our hopeful love for our jobs, which I mean how could you not. Some days are more difficult than others, but there's reason why we get up everyday and do what we do with a very trying population.
>
> JEROME - It's almost like you become more bonded to the profession. You become enlightened. The enlightened therapist versus the non-enlightened therapist. It's like you don't know what you don't know, and then when you know it you try to fit to that. You say, "Okay. Well, this is something I'm trying to commit to being, and hopefully it'll improve."

LYNN - I liked the little knot, the little pretzel of hope, love, and professional identity so that was for me the most visually and also the most conceptually attractive part of it because I think that that, for anybody who's gonna do work with clients that have disabilities I hope they have all of those interests included in there. The sense of purpose.

NATALIE - There's a lot of arrows everywhere, but when you look at them, it all makes sense. I thought it was so sweet putting love and hope and a sense of purpose. Of course we have our professional identity, but why did we decide on this profession and then develop this identity as this professional in this field? A lot of it is I think for love of humans. It's just like love for humanity, and then so every patient, client that we see, we have hope for them because we care so much. I like that little ending as well.

Moreover, counselors also confirmed the link between *lived experiences* with disability and *personal work* when working towards the achievement of *sense of purpose*. Queen reflected on the importance of lived experiences for counselors and further expanded her view of these experiences as usually being unrecognized when discussing the factors that inform development. Queen described her experience in this way,

QUEEN - I will say the thing that I'm finding I was kind of the most intrigued by was this aspect of lived experience in the counselor development area, because I think as a profession we've worked really hard to stay away from talking about a lot of that, in terms of ... I don't even really know what to say about that. I think because of the continued need and value of ensuring that we're viewed as being research based, and being scientifically based, sometimes I think the lived experience doesn't get as much recognition as perhaps it should. I'm just really appreciative that that's in there, and the personal work following that. I'll say I think this really resonates.

Also, some participants reflected on the complexity of factors present in the processes involved in their perceived development of competence to work with clients with disabilities and the overall *sense of purpose* as licensed professional counselors. Maria and Cortina dimensionalized the *sense of purpose* and extended it to the different parts of the diagram. Below is Maria's substantiation of the idea of *sense of purpose* permeating and informing all pieces of the analysis and driving professional identity, and also Cortina's comments that situate sense of purpose and professional identity as lifelong paths.

MARIA - I think if a layperson came in that didn't know what we did on a daily basis, they would be blown away by this diagram with all these different proponents in there. Because they think all we do is sit and talk to clients, and they leave, and we go on to the next one, and that's it. Our day is over. But there's so much more to it, and there should be more to it. Obviously working in a clinic we have a lot of regulations that we have to adhere to. […] Honestly, I think even though you have sense of purpose technically at the end, to me that's the whole point of all this. It could be at the beginning and the end and the middle. Because that is what our job is, and that's why we hopefully all come to this profession. That we want to help someone and have them feel better about themselves, and be successful. But yes, it takes all those different variances and dynamics to sometimes, most of the time, get to that part. But in my heart, that's what starts it, and ends it ultimately.

CORTINA - To get to that sense of purpose may be, you know, a lifelong path.

In summary, during the second interpretive dialogue interviews, the participants confirmed the category **Evolving Compromises** as well as the properties *negative attitudes*, *self-initiation*, and *sense of purpose*. Specifically, participants expressed high resonance with the

description of the transition from earlier stages of development that were highly influenced by *negative attitudes* and personal reactions, and that, over time, led to *self-initiation* and *sense of purpose* when mediated by factors as ethical decision making process, lived experience, personal work, and reflexivity. The fourth category discussed with the participants during the second interpretive dialogue interviews was **Competence**. In this category, the participants also confirmed its resonance with the amplified descriptions in this version of the emerging analysis.

Competence

Overall, the participants confirmed the interpretive factors embedded in the category of **Competence**. The participants also expressed their resonance with the depiction of competence in the diagram. The first property within this category, *recognizing disability as a cultural group*, was consistently corroborated by different participants during the second interpretive dialogue interviews. For instance, Maria highlighted the importance of recognizing deaf clients as part of a unique cultural group.

> MARIA - Recognizing the disability as a cultural group, which I think is a newer focus. Even working with clients that are deaf, a lot of people don't realize that's a culture. They're very steeped in that culture. It means a lot to them. Not negating that, and really embracing that and understanding. Even if you can't understand it 100 percent, but asking questions and being interested. That type of thing.

At the same time, the participants confirmed the properties of *consciousness* and *dimensions of oppression* within the category of **Competence**. Therefore, as the participants reflected on the emerging analysis, they actively established connections and made meaning between the analytic elements portrayed in the diagram. For instance, Queen established linkages between *reflexivity* and the ability of counselors to disrupt *dimensions of oppression* that impact

their clients by ***understanding and using their privilege*** when developing competence to work

with clients with disabilities. Moreover, Natalie also expressed her resonance to the graphic

depiction of **Competence** within the integrative analysis. Moreover,

> QUEEN - I'm appreciative of it [adding the analytic factor ***understanding and using***
>
> ***privilege***], because I think one of the things, again, my focus on how my lived experience
>
> and personal work has really informed me has probably done far more to inform me than
>
> a lot else. I'm grateful that I had some academic experience to help me build an
>
> understanding, but I think from this social justice aspect that I'm more comfortable with
>
> the idea of using lived experience and personal work to help inform my work with
>
> people. Because I've made the commitment to continue to look at myself, and be aware of
>
> the conflicts that I feel come up for myself, and talk to people about that, and try to do
>
> some of the professional consultation I might need to rectify that stuff. Which I do think
>
> is one of the things that will inform my competence.
>
> NATALIE - I liked sort of how there was a little sandwich and how it was like the top to
>
> the bottom, the bottom to top. Yeah, because there's therapeutic work, which is the
>
> hands-on part and looking at what's actually happening in the real world systemically.

Thus, the addition of the analytic factor ***understanding and using privilege*** was

consistently confirmed by the participants during the second interpretive dialogue interviews.

The participants further reflected on the different dimensions of ***understanding and using***

privilege for enhancing empathy and galvanizing counselor's advocacy potential through the role

of an ally of their clients. For instance, Faith described how reading the analysis increased her

level of awareness about her potential for using her privilege in the system. Lynn confirmed the

importance of understanding and using one's privilege to create systemic change in the

counselors' immediate communities. Also, Kara provided an example of the importance of using one's privilege within the system to collaborate with the professional and client's community, and advocate for her client's access to services.

> FAITH - I think as far as reading through everything, I think the part that really got to me that hadn't ever been in my mind and I think it was, it just wasn't something I thought of myself, was that understanding and using the privilege. I think that, really was one that I don't know why it never came to mind, but as I went through and looked at it, it pointed out to me, "Wow, yeah that's true." I never really thought about that and how much that can play a part into things. But it's really, really important to look at.

> LYNN - So I think that that's only at the very basic level, is having some awareness to have some appreciation for differences. But I think being able to apply that within a systemic frame is really important. I think using privilege as a way to navigate systems that might be unfamiliar, that might be unfriendly, that might be unhelpful, that might be continually built upon an uneven and inequitable system I think is really important. I like that you have self-advocacy as being equally as important as advocacy. Because I think that a counselor's ability to advocate is really important. I also think that counselor's ability to promote self-advocacy is really important, but I think that neither one of those things can always be privileged over the other because it's gonna be different depending on the client, depending on their capabilities, depending on their access. So I think that that was important. I think that the level that you have of becoming an ally, it's an interesting thing because people would throw around the word ally a lot and it's only [recently] that I've realized how much that terms gets used as a token gesture instead of a commitment to learning and to really developing skills. If I say I'm an ally, that can't just

be about how I feel. It has to be about what I do and I think that that's a shift that the system ... the counseling profession needs to continue to make. That we see ally as something that requires action. It's not just a mindset or a button that you can pin on your jacket.

KARA - With that client with the Medicaid issue I was able to resolve it by getting him Medicaid and now he's currently inpatient. That was definitely a success story and it was definitely navigated, I think, by the collaborative effort of talking with his brother who was also in the program, that was an obstacle. Then talking to insurance advocates and the inpatient programs as well as the homeless shelter. It was definitely a collaborative effort and a systematic process with working within our communities.

As a researcher informed by disability studies, I considered Lynn's comment to be powerful and illustrative of the distance between theory and practice related to advocacy and social change, specifically as it pertains to the training of counselors. Thus, my positionality as an emerging educator and scholar informed by disability studies within counselor educator made me deem these ideas relevant to the descriptions of disability competence. Moreover, Henry further summed up his understanding of the connection between the different pieces of the analysis based on his experience, and confirmed his resonance with the graphic elements that portrayed **Competence**. Specifically, Henry commented on the importance of *consciousness* to overcome negative attitudes, enact disruptive practices, enhance professional identity, help clients, and achieve *sense of purpose*. Henry described this in the following manner:

HENRY - So I remember descriptions that we had about some things are beneficial for the client but also things that are going on inside of us when we're working with someone who has disabilities. And like I kind of put disrupting practices in there. Because there

are certain things that we'll struggle with that if we're not feeling […] I don't want to say evolving our commitment but there are some things throughout this that can get in the way. Consciousness and becoming aware of that and also being about to view the clients needs I think are a great way to kind of overcome that. And I think that is a good thing to have right before a sense of purpose. Those three things come together and kind of help the person to be genuine. And then also when you're genuine with yourself you can identify your professional identity and enjoyment for working with the population, even though they are diagnosed with a disability, can improve.

In summary, during the second interpretive dialogue interviews, the participants confirmed the category **Competence** as well as the properties ***disability as a cultural group***, ***consciousness***, ***interrelated work***, and ***dimensions of oppression*** along with the additional analytic factor of ***understanding and using privilege***. Thus, the participants overall confirmed the importance of recognizing disability as a diverse cultural group with unique needs and history. Also, participants corroborated the need to cultivate awareness about the dimensions of oppression impacting their clients, collaborate with others, and embody the role of an ally to advocate for the client's needs as fundamental parts of developing competence to work with clients with disabilities. Thus, the participants confirmed the need to actively disrupt the dimensions of oppression that impact the lives of disabled clients. The final category discussed with the participants during the second interpretive dialogue interviews was **Systemic Dimension**s. In this category, the participants further confirmed its resonance with their experience of developing competence to work with clients with disabilities.

Systemic Dimensions

All participants confirmed the presence and influence of **Systemic Dimensions** in their perceived development of competence to work with clients with disabilities. Many participants expanded their descriptions about **Systemic Dimensions** when highlighting their experiences related to the dimension *system's fantasies of cure* within the analytic factor of ***counseling focus*** in the category **The Therapeutic Work**. However, Henry confirmed the understanding of the client's being in a ***double bind*** and expanded this to the counselors who are in the middle of forces that pressure them to meet the client's goals while also securing ***productivity in the mental health system***. Kara further expanded the impact of the pressures for productivity in her clinical practice and directly related this to lack of time and potentially detrimental outcomes for the client.

> HENRY - I think that actually is pretty important especially when you talk about like the systemic dimensions. I remember talking about specifically about the double bind. We also have to try to make sure we meet all the clients' needs but have an ongoing pressure to see more clients. And then also trying to be flexible enough to make sure that we are doing what we're doing with the client being flexible to meet their needs. I think that's a really, I think a lot of us are kind of hitting right on red, but that sandwich part is really what's sticking out to me the most. And then that part I just think is absolutely awesome. Its like an overall process.
>
> KARA - because sometimes too if you- especially I right now have a lot of the needier clients on my caseload and it's a lot of case management in between appointments that I don't necessarily get credit for in regards to my statistics, or agency stats or whatever. I'm able to offer them those services but if those other clinicians maybe wouldn't be, or if I

had treatment plans and paperwork due I'm able to say "I'm going to put that to the side right now because this patient's in front of me and needs me", but if you don't have that ability then, again, the client's suffering and whatnot.

Moreover, most participants confirmed the *systematic silence of disability* in their trainings as a problematic factor in their perceived development of competence to work with clients with disabilities. Only one person expanded her views about this silence. Tela expressed her resonance with the systematic silence of disability described in the emerging analysis, and mainly related it to the lack of recognition of disability as a culture within cultural competence trainings. The excerpt below describes her experience.

> TELA - Well, I think the part that probably is pretty striking is the understanding of when there is cultural competence trainings that disabilities are somewhat invisible in those. Just how there might be, maybe, more specialized trainings around different disabilities. But as a culture, it's not really covered in cultural competencies.

Finally, in terms of the systemic dimension of *prejudice and stigma* that surrounds disability, some participants confirmed and linked this property to *dimensions of oppression* within the category **Competence**. For instance, Natalie confirmed the importance of recognizing *disability as a cultural group* while recognizing the *prejudice and stigma* impacting the clients by consistently engaging in *reflexivity* as mental health counselors.

> NATALIE - I think that really put a good visual to it. Disability as a cultural group, I think that's really important. Whether or not your client does identify with the community or not, recognizing prejudice and stigma, obviously, because that also goes back to us then seeing what we don't have to deal with in terms of prejudice or stigma in society. That goes back to us then understanding our privilege, and then using it in a positive way,

right? Oppression and stigma and prejudice. One thing that I just was looking at from personal work, I like that that sort of led into that's one of the pieces that flows into understanding your own privilege and then using it in a positive way. That then leads down to right towards at the end of this process of full-blown consciousness.

In summary, all the participants confirmed the presence, impact, and importance of the category of **Systemic Dimensions** as well as its properties of ***double bind***, ***silence of disability***, ***productivity in mental health systems***, and ***prejudice and stigma*** in their perceptions of the development of competence to work with clients with disabilities. When confirming this category during the second interpretive dialogue interviews, the participants further linked the category of Systemic Dimensions and its properties to other elements within the analysis, as well as confirmed their resonance with the integrative process depicted in Figure 16. Therefore, all participants confirmed the emerging grounded theory during the second and final interpretive dialogue interviews. The next section illustrates the participants' comments around their confirmation of the overall theory based on their own experiences.

Summary of Participants' Confirmation of Theory Integration

As a final part of the interpretive dialogue interviews, I asked the participants their impressions about the extent to which the emerging analysis illustrated their experiences of developing competence to work with clients with disabilities. I worked to position this analysis and its graphic representation as one of the many ways to represent their experiences, based on my own experiences and cultural framework. Furthermore, I actively engaged each participant in the discussion of potential additions and revisions needed according to their experiences.

Overall, the participants expressed high levels of resonance with the analysis presented and indicated their view of it being strong, comprehensive, and representative of their

experience. Whereas some participants highlighted the level of fit with their perceptions of

development of competence to work with clients with disabilities, others reflected on the

integrative nature of the write up and diagram that attended the many nuances present through

the different interviews. For instance, Lynn emphasized the level of resonance between the

analysis and her own experience. DDD and Maria reflected on their appreciation for the

integration of different systems at play in the work with clients with disabilities.

> LYNN - I think as a whole, it feels resonant. It feels like it's representative of at least my
> experience.

> DDD - I think I really liked how ... I guess I liked how you had a lot of different
> components with it actually. Which I get is over-simplified but I almost was glad that it
> wasn't just one circle ... Or something like that, that there's a lot of different components
> that go into it, and that made me feel like you were able to capture the fact that this is
> complicated that there's a lot of different systems in play, whether it's an individual or
> within their disability community or whatever else. And so I really appreciated that you
> tried to take something that's very complicated and multi-dimensional and exemplified
> that in a visual way, which can get really complicated.

> MARIA - I'm amazed by all that you've done and I think you've really encompassed the
> entire thing really well. Because this is not an easy thing to sit down and concretely
> explain. I think you've done a really good job meeting with all of us and doing that.
> Because it's kind of almost, I'm going to be silly, but it almost feels like a mystical thing
> sometimes. Because you just don't, everybody does it a little bit differently. We all have
> our backgrounds and that type of thing. To actually be able to put it into this type of
> diagram is pretty amazing. I like that.

Additionally, many participants expressed a heightened level of insight and awareness related to disability in their clinical practice after engaging in the research process and reading the emerging analysis. For instance, Unice commented and thanked the research team for her heightened awareness and renewed motivation about this issue, and Allison described this in terms of "opening her eyes" to her lack of knowledge in disability issues. Also, Henry and Iris expressed the novelty of this area of insight after engaging in the research process and reading the emerging analysis.

UNICE - I want to thank you for reaching out to me to be a part of this because you've been able to kind of reinforce some of the work that I do, validate, motivate me. Just by the separate conversations that we've had although brief, it has gotten my wheels turning again in a very refreshing direction. So this has been quite enjoyable and quite refreshing. I want to thank you for that.

ALLISON - What I loved about this was it opened my eyes to how little I know but then it always told me I do know a lot. And I think really, it's hard.

HENRY - I never really thought about it. I think it's certainly the last time when we were speaking. I never thought about it just in depth. And as I'm thinking about it, every step I'm looking at it's like, yeah that makes sense.

IRIS - Okay, my overall impression? Yeah you know my overall impression is my God, I've never thought of my development and growth with working with people disabilities like this, ever. You don't, you just plow through and go to work every day and do the things that you had mentioned in here. Supervision and research and growth and thinking and interacting and changing. But you never really sit down and think about your professional growth in this manner. Which is what you're doing. It's pretty cool.

Moreover, along with the many confirmatory reflections of the participants about the analysis and the diagram, many of them emphasized their resonance with the process depicted which they interpreted as being inherently complex, fluid, and ongoing in nature. Cortina, Faith and Jerome commented on how the flow of the analysis and diagram made sense for them, whereas DDD and Maria expressed how the process described in the analysis is not linear, but dynamic and intertwined, and depends on the client and the counselor.

CORTINA - The flow of it, when we start at points of encounter, and then I can read to the right, then go down and to the left. That makes sense.

FAITH - I think it's really good. I think it helps to explain it really well. I think it's the flow. I think it shows the flow really well and the different directions it can go in and it is, it's a constant flow back and forth. I don't think it's straight. It's not a straight line kind of thing. It is, goes all over.

JEROME - I think it makes perfect sense. I thought the beginning, the first pieces that you talked about, the steps of the sequence made very clear sense to me. I knew what you were talking about.

DDD - I did like how it, I almost wish that there was more, but I can totally understand this, about how it's not necessarily so linear. You know what I mean? Because depending on the counselor development I can see how things could get like [...] You could just jump from one to the other. Maybe this is just [...] To the ideal, the ideal evolution, however I imagine that ... If you weren't aware of this or if you didn't have this understanding you could skip a lot of this. Or if you're reflecting on your own competencies or development you might go back to different parts of this, but overall I think it outlines a really great pattern.

MARIA - Your arrows do go. They have a flow to them, but they also have little offshoots. I think that's accurate, because there's no one specific way to do something with a client. Everyone is different. You might have to jump in at a certain point.

In summary, the participants indicated high levels of resonance with the emergent grounded theory related to their perceptions of development of competence to work with clients with disabilities. The second and final interpretive dialogue interviews afforded the participants' confirmation of the written emerging analysis as well as the diagram illustrative of the grounded theory. Moreover, participants not only confirmed the different elements encompassed in this analysis, but they also reflected on their own process of disability consciousness as they have engaged in the research process.

External Auditor's Confirmation of the Emerging Analysis

As mentioned in Chapter III, it was my intention to ensure trustworthiness of my study by triangulating the data sources to include different perspectives during this qualitative inquiry (Hays & Singh, 2012). Specifically, I intended to triangulate the data sources by integrating the perspective of an external auditor who would determine the extent to which the emerging analysis represented research rigor by accurately representing the participants' descriptions. For this purpose, a licensed professional counselor unrelated to the data collection served in the capacity of an external auditor as a final step in the analysis process. This licensed professional counselor was recruited towards the end of the data collection process, using the same strategy used to recruit the rest of the participants. The external auditor recruited for this study was a 30 year old licensed mental health counselor who graduated in 2013 from her CACREP-accredited counseling program. The external auditor who self-identified as having intimate knowledge about the research topic based on her professional experience as a licensed mental health

counselor and her lived experiences as a person with a physical disability. The external auditor had lived with a physical disability for over twenty years.

After the external auditor was recruited and the second interpretive dialogue interviews were completed, I prepared a set of participants' transcripts and the final version of the emerging analysis, and sent them to the external auditor for review and feedback. The participant transcripts included the set of four points of contact (first interview, first interpretive dialogue interview, second interview, and second interpretive dialogue interview) for two participants as well as three other sample transcripts. After the external auditor reviewed the materials sent, a phone call was arranged to discuss the overall feedback of the analysis. During this call, the external auditor expressed her resonance with different parts of the analysis as a professional counselor with a disability, such as the systematic silence of disability. As a disabled counselor, the external auditor expressed her strong resonance with the pervasive and systematic absence of disability issues in training, curricula, research, and overall clinical practice. The researcher and the external auditor discussed and clarified their understanding around different parts of the analysis.

For instance, the external auditor questioned the assumed directionality of the analysis and its depiction in Figure 16. As a researcher, I engaged with the external auditor in clarifying the representation of the processes I identified based on the participants' perceptions of development competence, and positioned this representation as a tool to illustrate these processes instead of an objective and absolute representation of the phenomenon. The external auditor and I agreed on the fluid and non-directional nature of the processes represented in Figure 16. The external auditor corroborated the integrative and comprehensive nature of the analysis, and recognized the researcher's accurate and respectful portrayal of the participants' descriptions.

Additionally, the external auditor asserted how each of the components described by the participants in the transcripts was carefully and meaningfully related back to the main argument in the emerging analysis. As this the last step in the analysis process, the external auditor corroborations of the emerging analysis signaled the transition to crafting the final version of the grounded theory about counselors' perceptions of their development of competence to work with clients with disabilities to be described in the following chapter.

Conclusion

The second round of analysis led to the identification of analytic factors that were integrated into the emerging analysis and confirmed by all participants during the second interpretive dialogue interviews. Moreover, the participants also reflected on and confirmed the overall existing categories and properties that are encompassed in the emerging analysis as well as the grounded theory diagram (Figure 16) that describes the participants perceived development of competence to work with clients with disabilities. Thus, as my participants engaged in the second interpretive dialogue interviews, I worked to capture refined descriptions of their perceptions of the analysis as well as their level of resonance with the emerging categories and properties already established.

In doing this, the participants more actively linked categories and properties with one another when describing their experiences. These resulting interpretive synergies between categories identified by the participants were enhanced and facilitated by their examination of the emerging analysis' diagram (Figure 16). Therefore, during the second and final interpretive dialogue interviews, the participants did not identify major expansions or adjustments of the categories or their properties. Instead, the participants corroborated the existing categories,

additional analytic factors, and the semantic and interpretive changes related to **Evolving Commitments** and ***becoming vs. overcoming***.

At this point of the research engagement with my participants, it was my experience that they comfortably expressed their confirmations and honest feedback of the emerging analysis. The continuous research engagement with my participants through multiple points of contact facilitated their increased level of trust and collaborative investment in the descriptions of their experiences. Thus, the second interpretive dialogue interviews afforded a final opportunity for strengthening the research design by ensuring trustworthiness related to comfirmability. In short, these interpretive dialogue interviews deepened the interpretive power of the emerging analysis related to their experiences of developing competence to work with clients with disabilities.

Moreover, I sought to increase the study's dependability and comfirmability by striving for a co-construction and interpretive consensus of the analysis, which included the participants, research team, and auditor to agree upon the emerging analysis. This external auditor was recruited towards the end of the data collection. After reviewing the emerging analysis an a set of participants' transcripts, the external auditor further confirmed the emerging analysis as accurately and respectfully portraying the participants' descriptions of the their experience with the phenomenon. Next, Chapter VIII formally presents the emergent grounded theory that was co-constructed with my participants about their process of development of disability competence. The final chapter also elaborates on the research implications, limitations, and recommendations emerging from this study.

Chapter VIII: Grounded Theory of Licensed Professional Counselors'

Perceptions of their Development of Disability Counseling Competence

Introduction

This final chapter illustrates the emergent grounded theory of licensed professional counselors' perceptions about their development of disability counseling competence. This investigation entailed a rigorous and systematic approach to capturing and understanding the categories, properties, dimensions, and processes involved in the participants' experiences of developing disability counseling competence. Moreover, in this study, the depiction of these complex processes entailed narrative and graphic illustrations that were refined throughout the data collection and analysis process. For this purpose, this study used qualitative inquiry, specifically the grounded theory qualitative tradition (Corbin & Strauss, 2015), to explore the professional counselors' experiences in how they developed disability counseling competence.

As mentioned earlier, this qualitative tradition afforded the co-construction of a theory grounded in participants' descriptions of their lived experiences. The research design integrated theory, clinical practice, and social and cultural contexts specific to the participants in ways that few other qualitative approaches can assert. Thus, the use of grounded theory allowed me to explore the intricacies of disability counseling competence and to co-construct knowledge (Hays & Singh, 2012) regarding participants' perceptions of how disability counseling competence develops. Additionally, in order to ensure research integrity and trustworthiness, I engaged in several strategies that will be described later in this chapter.

Even though twenty-one participants were initially recruited and interviewed, only twenty licensed professional counselors participated in the entirety of this investigation. One participant did not engage in the research process after the first interview. These twenty participants actively

engaged in the process. Specifically, the data collection phase of this study included two rounds of qualitative interviews and two individual interpretive dialogue interviews with each participant that were conducted from the end of the Fall semester 2016 to the middle of the Spring semester 2017. All the participants were working with clients with disabilities, and throughout their engagement in the research process, they provided detailed and rich descriptions of their clinical work and their process of developing disability counseling competence. All interviews were conducted in English and were audio recorded and professionally transcribed. Moreover, all the interviews were coded to identify the emerging categories, properties, and analytic factors that most accurately described the participants' development of disability counseling competence.

During the first round of interviews and analysis, five emerging categories were identified. These categories were *The Therapeutic Work*, *"It Takes a Village," Evolving Compromises*, *Competence*, and *Systemic Dimensions*. The investment of the participants allowed me to identify the emerging properties that substantiated each of these categories. Perhaps the most important revelation within the initial analysis was the collaborative and community-oriented nature of the work of counselors when examining their development of disability counseling competence. This factor was not only remarked upon during round one, but it continued to be reflected upon and confirmed during the second round of interviews.

The second round of interviews and analysis afforded the identification of additional analytic factors as well as the co-constructed adjustment over semantic and interpretive components. These analytic factors were *ethical decision making*, *client's community*, *understanding and using privilege*, and *counseling focus*. Moreover, adjustments included the substitution of the word "compromises" for "commitments" as one of the categories, and the

refinement of the property of becoming vs. overcoming as a counseling focus. Each of the categories identified during the first and second round of analysis were seen as laying the groundwork for the participants' perceptions about their development of disability counseling competence. These textual descriptions also served as a catalyst for the creation of graphic illustrations about the dimensions and processes involved in the counselors' development of disability counseling competence (See Figure 17). Additionally, the theoretical and illustrated descriptions that emerged during each round of analysis and were confirmed and expanded during the interpretive dialogue interviews. The next section in this chapter presents the final description and diagram that captured the emergent grounded theory about licensed professional counselors' development of disability counseling competence.

Researcher's Co-Constructed Conceptualization of the Emergent Grounded Theory

The emergent grounded theory of licensed professional counselors' development of disability counseling competence that is presented in this chapter is the result of an engaged process of examination and construction of participants' experiences with this phenomenon. The co-construction of this grounded theory entailed a systematic engagement in participants' experiences, as well as multiple confirmations of the emerging results in order to capture and represent their experience in the most accurate way possible (Hays & Singh, 2012). The final version of this emergent grounded theory is further illustrated in an integrative narrative and graphic description (please see Figure 17). In this figure I attempt to organize the emerging findings; however, as a researcher, I firmly detach from linear or organized claims of the counselor's development. Thus, this graphic representation responds to my own ways to make meaning and does not assume strict directionality between the analytic factors described by the participants.

For many of the counselors, the process of developing competence usually began when participants encountered clients with disabilities in their clinical practice. This starting point was named the Point of Encounter with Disability in the integrative diagram. Even though many participants related this encounter with disability to the clinical experiences within their training, when professional counselors encountered clients with disabilities in their professional practice, participants experienced an enhanced sense of responsibility for accounting for the service to these clients as licensed professionals. Moreover, for counselors working in community agencies and schools, the assignment of these clients to their caseloads was usually directed by their immediate supervisors.

Many of the counselors who encountered clients with disabilities in their clinical practice often experienced the presence and impact of ***negative attitudes*** that involved the realization of the lack of interest for this population, lack of training in disability matters, lack of exposure during professional practice, lack of confidence to engage these clients, and ultimately, diminished competence to work with this population. In this study, at least fifteen participants' attitudes were strongly linked to significant reactions of fear, pity, sadness, frustration, discomfort, powerlessness, and avoidance to working with this population. Many of these participants' descriptions of these reactions are consistent with counseling literature mentioned in Chapter II which documented the pervasive and potentially negative reactions of counselors in training when engaging in conversations about multicultural difference, specifically related to disability. For instance, the description of these counselors' reactions are theoretically congruent with Parkinson (2006) and Watt et al. (2009) who found a strong presence of ableist narratives relate to loss and pity about disabled clients in counselors in training. Moreover, counselor bias has demonstrated to have a detrimental impact on clients with disabilities (Reeve, 2000; Smart &

Smart, 2006; Smith et al., 2008). Other participants expressed more affirmative and respectful attitudes and situated their lack of exposure as the main reason for their experienced lack of competence.

Whereas the presence of these negative attitudes and the emergence of these reactions strongly informed earlier stages of counselor development for some participants, many of them were able to move forward in their perceived development when cultivating and igniting commitments related to ethics and reflexivity through personal work. For some counselors, their perceived development was further mediated by process variables of ethical decision making process, lived experience, personal work, and reflexivity. For instance, engaging in ***ethical decision making*** by honoring commitments for reflexivity and self-initiation afforded two participants to come to terms with the reasons that informed their reluctance or trepidation to provide services to clients with disabilities. Furthermore, the lived experiences that had the most impact for at least eighteen counselors were counselor's growth and maturity, as well as personal experiences with disability. These process variables helped many counselors, over time, change their initial negative attitudes to more affirmative reactions about working with clients with disabilities. However, two participants who had extensive personal experiences with disabilities still manifested negative attitudes and did not transition through other facets of development. Thus, for many counselors, their perceived development became a dynamic and fluid process of negotiating and resolving the impact of initial biases in order to enact a professional disposition of openness to ***self-initiation***.

The description of this dynamic and fluid process is corroborated by the literature. For instance, in their study about the influence of students' socio-cognitive development on attitudes toward people with disabilities, Sheaffer et al. (2008) asserted that counseling students at earlier

stages of socio-cognitive development manifested a preference for higher preferred social distance compared to those in more advanced stages of socio-cognitive development. Sheaffer et al.'s (2008) findings not only substantiate the developmental dimensions of the emergence and enactment of negative attitudes towards people with disabilities, but it supports the possibility of counselors moving beyond these attitudes when engaging in growth-promoting commitments that facilitate their development. Moreover, Sheaffer et al.'s (2008) assertions also affirm the relevance of reflexivity and personal work in the process of development as a way to address the emergence of biases toward persons with disabilities, which have been identified as potentially leading to further marginalization for clients with disabilities (Reeve, 2000; Smart & Smart, 2006; Smith et al., 2008).

For the majority of counselors, as they progressed in their development and engaged in the process variables mentioned previously, they experienced a heightened potential for self-initiation. These counselors' self-initiation was strongly related to the realization that **"It Takes a Village"** to develop competencies outside one's own identity. Many of the counselors demonstrated self-initiation by being able to connect with their professional communities, or "village," for learning and development through experience and exposure. The professional village was encompassing of professional partnerships with clinical supervisors, peers, and other mental health professionals across collaborative relationships. The nature of these interchanges facilitated an interrelated work with their professional and learning communities that further enhanced counselors' knowledge base and resourcefulness to individualize the approach to their clients. The learning communities embedded in the professional village extended beyond graduate counseling programs and included professional development opportunities in the form of institutional trainings and professional conferences. These learning communities were further

dimensionalized based on state, region, and the access to social media. Other counselors expressed difficulties to actively access a broader professional community. For instance, two participant expressed that the village becomes almost unavailable for counselors working in private practice, when compared to counselors working in institutional settings.

Counselors' self-initiation to connect to their professional village, and specifically to the learning communities embedded in it, warranted their accrual of cultural information about disability. Ratts and Pedersen (2014) highlighted the importance for counselors to self-initiate and learn the cultural knowledge and information of unfamiliar populations through the access to a broader network of professional support. Thus, the professional network surrounding the participants were essential supports. Moreover, as illustrated in the integrative diagram in Figure 17, for many of the counselors, their connection to the professional village evolved through clinical experience and exposure to clients with disabilities. This analytic component is also substantiated by the counseling literature. Specifically, Smith et al. (2008) highlighted the importance for counselor trainees to intentionally and consistently engage in the service of clients with disabilities in order to increase disability awareness. This assertion can be extended as a reinforcing factor within counseling professional practice aimed to be a catalyst for the development of competence to work with individuals with disabilities.

As many of the counselors engaged in these partnerships and learned from professional and learning communities, they eventually developed close networks of professional and personal support, or *circles of trust*, in their clinical work. This process facilitated self-initiated learning by actively connecting with clients and family narratives, which further led the majority of the counselors to inquire in cultural issues pertaining to their client's life circumstances. Those counselors who did not inquire in client's cultural issues, considered these as not pertaining to

the goals of therapy or related to the nature of the counseling work. This analytic component is congruent with literature that calls for approaches that extend from individual counseling work and recognize the variety of systems that are in contact with the client (i.e., family, school, society). This expanded and systemically oriented attention has also been called upon within disability studies (Shakespeare, 2013) and counselor education (Ratts & Pedersen, 2014).

Furthermore, four participants added a layer to the professional village by naming the disabled community, or ***client's community***, as an additional dimension of the context where counselors operate. The inclusion of this community dimension emphasizes the potential for counselors' learning and consultation represented by the disabled community. The presence of the client's community further highlights the importance of the inclusion of disabled subjectivities in the professional realms of mental health counseling (Charlton, 1998; Linton, 1998; Olkin & Pledger, 2003; Shakespeare, 2013).

At this point of the process, many of the counselors experienced a variety of realizations related to the recognition of disability as a cultural group. These realizations were catalysts for counselors to ***recognize disability as an identity*** with its own history of disenfranchisement, marginalization, and resistance. Progressively, many counselors became aware of the multilayered dimensions of oppression that people with disabilities have historically and presently encountered, based on problematic assumptions of capability, worth, and citizenship, as well as the social movements aimed to counteract this impact. In this process, seventeen participants recognized that these dimensions of oppression have further led to the perpetuation of prejudice and stigma in all aspects of the social fabric and also overlap with other aspects of identity, such as sexuality, gender identity, immigration status, social class, or race. The other

three participants made no clear connections between other aspects of identity and their impact on the work with clients with disability.

As noted in Chapter II, even though the multicultural force within the counseling profession has more intentionally accounted for the interplay of various and simultaneous social markers in people's lives (Ratts & Pedersen, 2014), there still persists an impulse for essentializing the explanations of disability in counseling (Reeve, 2000; Smart & Smart, 2006) based on medical assumptions of health and functionality (Davis, 2013; Linton, 1998). This analytic component of counselors' recognition of disability as a cultural group is congruent with disability studies' conceptualizations of identity where the overall social response to disability is instead used as an organizing experience that determines psychological, social, political, academic, occupation, relational, and material consequences for these clients (Shakespeare, 2013). A disability studies approach to disability is congruent with the current version of the multicultural and social justice competencies (Ratts et al., 2016) in that it seeks to address the systemic rather than the individual variables that inform individuals' lived experiences.

The presence and substantiality of awareness of clients' social realities for many counselors led to a heightened **Self-Perceived Disability Counseling Competence**. Up until this point, most counselors mainly reflected on their level of comfort related to working with clients with disabilities. Thus, many of these counselors became aware of the variables that facilitated their comfort when working with clients with disabilities, and those variables that hindered their approach to this work.

This self-perceived disability counseling competence was reflected in the counselors' **Therapeutic Work** through a variety of factors. For instance, all the participants experienced the ability to ground their professional role in the ***counseling relationship***. They described the

counseling relationship as the ability to form a therapeutic alliance with the clients that conveyed authenticity, unconditional positive regard, and empathy. According to the participants, the connection with their clients was further enhanced when they tailored their approach to meet their particular needs (Dodson, 2013; Ratts & Pedersen, 2014).

Therapeutic work was also reflected in twelve counselors' commitment to remain flexible and creative when tailoring the approach to meet the individualized needs of their clients with disabilities. As stated in Chapter II, multicultural skills relate to the planning, conducting, and evaluating of the multicultural context by interacting, counseling, interviewing, advising, and managing multicultural tasks effectively (Ratts & Pedersen, 2014). The participants highlighted the importance of meeting the clients where they are at by tailoring a counseling approach based on clients' unique cultural needs and circumstances.

In *tailoring the approach*, many counselors named the need to navigate tensions in current realities of the field. In particular, eight participants mentioned having to negotiate the field's *fantasies of cure* that seek to standardize and objectify the therapeutic process through measurable goals and objectives that demonstrate progress (i.e., client's adjustment, grief, loss), with honoring the *intentionality to embrace difference* by following the client's lead when defining the goals for treatment. Therapeutic fantasies of cure have been substantiated by Reeve (2000, 2006) who defined these as problematic assumptions of adjustment and loss that position disability as a psychologically devastating experience or personal tragedy requiring specialized (medical) intervention to progress towards wellness and optimum health (Ingleby, 2014). Moreover, according to these participants, fantasies of cure were also reflected in their own clinical practice through the continual creation and revision of treatment plans, goal, objectives, and interventions aimed to quantify and document client progress.

The majority of the counselors navigated the contemporary demands of counseling by honoring the intentionality to embrace the clients' identity and their capacity to lead and define the goals for treatment. This analytic component is congruent with an emphasis on the client's strengths and recognizes the capacity of individuals with disabilities to perform when optimal conditions exist within the environment (Brandt & Pope, 1997; Pledger, 2003; Swain et al., 2006). Thus, as many professional counselors developed self-perceived competence to navigate the demands of counseling clients with disabilities, they demonstrated the potential for delivering services that were embracing, affirmative, and aligned to the client's goals for treatment.

Developing self-perceived disability counseling competence was impacted by **Systemic Dimensions** that further influenced counselors' engagement to their learning communities. When unresolved, these systemic dimensions led some counselors' bias toward disability, which influenced their willingness or interest in working with clients with disabilities. One of the systemic dimensions impacting the counselors' perceptions of development of competence was the ***systematic silence of disability*** across graduate counselor education curriculum and learning domains. As the main expression of this absence, eighteen participants reported a lack of professional trainings focused on disability during their graduate training. Participants referred to the lack of disability representation in faculty, co-workers, curricula, and leadership positions within their local communities or professional organizations. Even though professional trainings related to disability were more present in counselors' site of employment, the amount of disability trainings typically ranged between none and one for at least thirteen participants.

The systematic silence or absence of disability has been documented in the counseling literature by different authors (i.e., Olkin, 1999; Olkin & Pledger, 2003; Pieterse et al., 2009; Pledger, 2003; Shin et al., 2011; Smart & Smart, 2006). For instance, as mentioned in Chapter II,

Pieterse et al. (2009) asserted that disability topics such as disability discrimination or ableism was represented in only 7 percent of the syllabi reviewed in their study. Moreover, Shin et al. (2011) documented the lack of representation of disabled students in counseling programs, potentially decreasing the representation of disabled counselors working in clinical positions.

Another dimension impacting some counselors' perceived development of disability counseling competence was the ***double bind*** represented by a system that embraces clients with disabilities to meet their needs, but that becomes inaccessible when clients try to take initiative to change their social circumstances. Some counselors expressed the many difficulties to learn and navigate these dynamics in order to advocate for their clients' needs given the contradicting positions in which counselors find themselves. For instance, one participant commented on her clients striving for wellness while having to remain "in need" enough to be able to keep government benefits. Also, many participants commented on the array of government benefits available for clients (i.e., SSI, housing, food stamps, transportation) as factors that help the clients cover basic needs while navigating the mental health system. For two participants, clients with disabilities actively contribute to staying in a double bind position by "using their disability as a clutch" and obtaining government benefits. The systemic dimension of double bind was understand differently depending on the participants' developmental level.

A final systemic dimension impacting many counselors' perceived development of disability counseling competence was the presence of increased demands for ***productivity in mental health systems***. Eighteen participants faced big caseloads, the pressure for measurable outcomes, the lack of recognition of the time invested in reaching out to their learning communities and for adapting counseling materials for specific populations (i.e., translating handouts). Moreover, productivity outcomes such as billable services and collaborative

interventions that explain the use of pharmaceutical intervention inform these systems of production that demand counselors' efficiency in the use of time and resources (Ingleby, 2014; Hansen, 2016). Such productivity outcomes consistently decrease the opportunities for learning and development. Hence, one aspect that was consistently emphasized by the majority of the participants in this regard was the lack of time to engage in self-initiation and reach the broader community.

As illustrated in the integrative diagram in Figure 17, the emergence of self-perceived disability counseling competence was reflected in three domains. The overlapping expression of these domains informed the counselors' therapeutic work, their navigation of systemic issues impacting their professional practice and the lives of their clients, as well as the counselors' disposition for further learning and integral development. Many counselors developed *consciousness* by actively implementing in their therapeutic work the recognition of systemic, socio-political, and policy aspects impacting the lives of their clients and highlighting the importance for social movements striving for equality within the disabled community. Furthermore, about eight counselors expressed reaching higher levels of consciousness about disability as they actively engaged in self-reflective practices aimed at understanding and using their privilege. The analytic factor of *understanding and using privilege*, as illustrated in Figure 17, builds a conduit between consciousness and personal work in order to depict the need for these reflexivity commitments to be enacted throughout the experience of developing competence.

Consciousness related to one's privilege has been illustrated in the counseling literature as multicultural awareness. Ratts and Pedersen (2014) positioned gaining awareness of privilege as an essential step in the process of developing multicultural competence and as the main tool to

realize able-bodied privilege (Reeve, 2000; Watt et al., 2009). Moreover, the USDHHS report (2001) and Matthews-Juarez and Juarez (2011), situated increased responsibility on counselors for the development of a culturally competent mental health system through their continual self-examination aimed at developing awareness of their own biases and stereotypes. Thus, when some counselors did not fully engage in reflexivity about the power represented in the counseling room and the often detrimental impact of systemic oppression on their clients' lives, they easily aligned with problematic narratives of disability that perpetuated medicalized and deficit ideas involving charity, loss, adjustment, and pathology as the core of their therapeutic work.

Many participants also strived for consciousness by unpacking the effects of mental health counselors representing a medicalized system that further perpetuates the continuation of services grounded in pathologizing views of the clients' lives. Thus, several counselors engaged in personal work and reflexivity to cultivate disability consciousness and use their privilege to increase empathy and to become allies/advocates of clients. This disposition to become allies, advocate and to support self-advocacy in clients was considered part of ***disrupting practices*** that reflect competence. This finding is congruent with Ratts et al. (2016), Reeve (2000), Smart and Smart (2006), who emphasized the need to understand one's privilege as well as the social complexities of disability as a marginalized identity as a counselor. Two other counselors considered that the counseling work needs to be focused on achieving treatment goals and did not see advocacy as a relevant part of their professional role.

Another domain in the enactment of perceived disability counseling competence was the presence of potentialized ***outcomes***. The majority of the counselors referred to evidence-based practices in their work with clients, but more importantly, to the ability to build meaningful relationships with clients that represented alliance, support, and hope. At this point, all the

participants claimed their alignment with affirmative and integrative approaches that recognized and helped them to navigate the systemic dimensions of the work, while embracing their clients for who they are and working in accordance to their expressed needs. Moreover, each of the elements described by the participants and situated in the diagram accounted for expressed commitments aimed to enhance their personal and professional development as licensed professional counselors working with clients with disabilities.

Consequently, the overall perception of development of disability counseling competence (see Figure 17) was reflective of the core category **Evolving Commitments**, which tied all pieces together and informed many counselors' personal and professional sense of purpose enacted through clinical practice. The majority of the counselors experienced a sense of purpose as licensed professional counselors by highlighting their capacity for instilling hope, feeling genuine and loving care for their clients, and having a deep belief in human dignity, as well as heightened professional identity that differentiated them from other mental health professionals working with clients with disabilities. Thus, for many counselors, the sense of purpose is represented by the interrelated and endless articulation of hope, love, and professional identity, and is only a part of the continual process of professional development that consistently links counselors to points of encounter with other populations and extends over the whole process (see Figure 17).

Therefore, in response to the first research question, how do licensed professional counselors develop competence to work with clients with disabilities? this analysis illuminates the many categories, properties, dimensions, and analytic factors related to the participants' perceptions of their development of disability counseling competence. Specifically, the multiple categories and dimensions illustrated in Figure 17 account for the participants' perceptions of a

process that oscillates within an array of developmental domains. As evidenced in my analysis, these developmental domains ranged from overt negative attitudes towards people with disabilities to affirmative and socially responsive views of different abilities with the collateral commitment for advocacy and professional sense of purpose at varying levels and developmental rhythm for different participants.

In response to the second research question, what does disability counseling competence look like in terms of counselors' self descriptions of practice? My analysis illuminated integrative descriptions of competence that were grounded in participants' perceptions. For the majority of the participants, self-perceived disability counseling competence entails the recognition of disability as a cultural group, requires counselor's consciousness, demands interrelated work, and seeks to highlight and disrupt the dimensions of oppression that impact the lives of clients with disabilities. Moreover, the majority of the participants described that their disability counseling competence is reflected in clinical practice through the domains of consciousness, disrupting practices, and potentialized outcomes. For other participants at earlier stages of development, disability counseling competence was heavily informed their ethical decision making and primed problematic dynamics that further perpetuated the exclusion of people with disabilities from counseling services.

As observed throughout the analysis, the domains that describe what is disability counseling competence are intertwined with other analytic categories and are also framed into the core category of counselors' evolving commitments. Even thought these descriptions offer an emerging conceptualization of what disability counseling competence looks like based on the participants' experiences, this research question has not been yet fully answered.

Finally, in response to the last research question, what are the similarities and differences of disability counseling competence compared to multicultural competence? the representations of many participants' experiences working with clients with disabilities further accounted for a more complex and multidimensional articulation of participants' multicultural competencies when effectively working with clients with disabilities. Even though the perceptions of disability counseling competence are fundamentally grounded in the main philosophical and clinical tenets of multicultural pluralism, the majority of participants' perceptions of disability counseling competence extended beyond the traditional realms of initial multicultural competence and proposed meaningful interdisciplinary and practical synergies within newest versions of multicultural and social justice competencies (Ratts et al., 2016) as well as disability studies (Reeve, 2000; Smart & Smart, 2006; Swain et al., 2006).

In other words, based on the majority of participants' descriptions, part of disability counseling competence overlaps with emerging conceptualizations of multicultural competence, and part of it represents a differentiated area of scholarly inquiry and clinical practice. Even though disability has increasingly become a legitimized area within the counseling discourse (i.e., through the launching of a disability specific track within CACREP-accredited training programs), the profession has not achieved resolution about the way to infuse it into counselor curriculum and how to position it within the multicultural discourse.

In terms of similarities, based on the summative descriptions of the processes involved in the perceptions of development of disability competence in this study, I was able to highlight the analytic dimensions for learning, understanding and using privilege, and delivering effective therapeutic approaches as reflective of the grounding aspects of multicultural competencies of knowledge, awareness, and skills (Ratts & Pedersen, 2014). Many counselors actively mentioned

the importance of knowledge, awareness, and skills as part of their multicultural preparation to work with clients with disabilities. However, it was evidenced that some counselors still hold problematic assumptions related to clients with disabilities and lack the knowledge and willingness to systematically reach out to people with disabilities for knowledge, support, and expertise. The competence to work with clients with disabilities has been continuously embedded in multicultural development theories instead of receiving specialized attention (Olkin and Pledger, 2003; Smart & Smart, 2006).

Hence, based on this study, I believe disability counseling competence needs to be situated as a particular area of multicultural action and demarcated as a separate competence within multicultural training in counselor education. For instance, disability counseling competence differs from multicultural competence in that it necessarily entails the recognition of the pride of disability as as a social movement, as well as the disrupting power emerging from the disabled community in order to inform counseling professional practice. Moreover, disability counseling competence differs from multicultural competence in that it requires counselors to recognize the complexities associated to disability as an identity. For instance, in this study, disability was framed as physical, developmental, cognitive, and sensorial. However, the lived experiences of disabled people evidence the complexities of disability in its intersections with time (i.e., genetic, acquired), social class, and race. The recognition of the complexities around disability as an identity can further enhance the possibilities for competence of counselors. This recognition necessarily disrupts singular and essentializing views of identity and affords counselors with more complex and human descriptions of lived experience.

The development of multicultural competence related to disability in clinical mental health settings has not received specialized and intentional attention in order to illuminate its

critical complexities (Olkin & Pledger, 2003). This emergent grounded theory serves to fill this research gap and provides the counseling profession with an in-depth understanding of the processes involved in the development of disability counseling competence, as it is perceived by licensed professional counselors. Thus, I deem it necessary for the counselor profession to establish disability counseling competence as a specific pedagogical area for counselor clinical development. In this way, the counseling profession can actively respond to social commitments through training and service.

This emergent grounded theory was co-constructed with the highest measures for ensured trustworthiness and integrity. In the following section, I will expand on the ways I used these measures for ensuring trustworthiness and credibility.
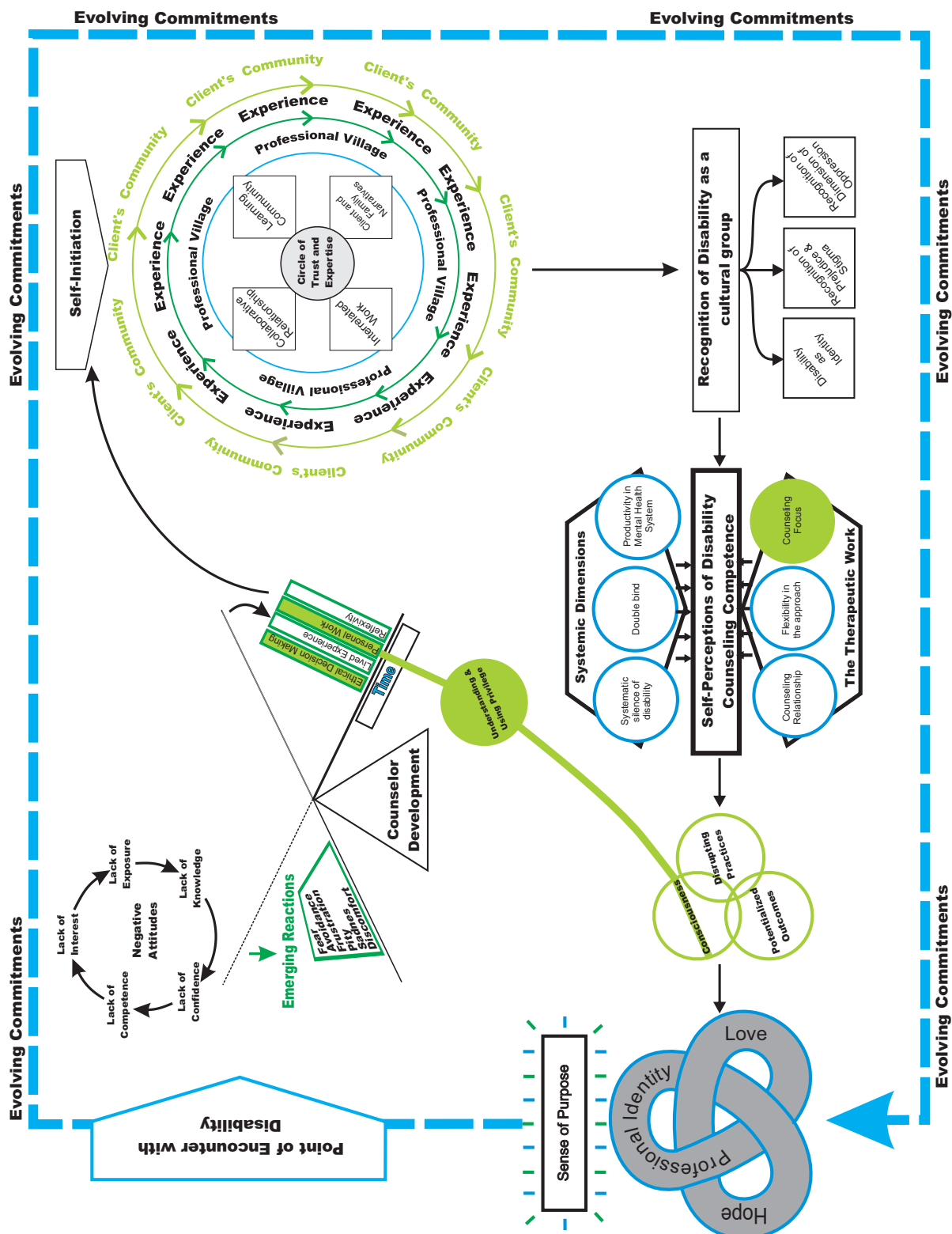
Figure 17. Final Emergent Grounded Theory Integration

Strategies Used to Ensure Trustworthiness

As mentioned in Chapter III, I embarked on this research process with the commitment for ensuring trustworthiness of the study. My ability to remain grounded in the literature, attentive and reflexive of my internal process of meaning making, and in connection with my research team allowed me to enact multiple trustworthiness strategies that enhanced the credibility of these results. In this section, I will expand on the ways I enacted these commitments for the most integral representation of my participants' stories, methodological consistency, and creativity (Corbin & Strauss, 2015). Specifically, I was able to engage in activities that pertained to all the trustworthiness criteria defined by Hays and Singh (2012), namely credibility, transferability, dependability, and comfirmability.

For the purpose of guaranteeing qualitative credibility, I engaged in diverse forms of documentation for enhanced record keeping, triangulation, and peer debriefing. Specifically, in this study, I worked to capture and document accurate descriptions from the participants throughout data collection by recording and transcribing all the interviews. Even though all interviews were conducted mainly in English, when interviewing participants who also spoke Spanish, I worked to clarify and reach consensus when we used a Spanish word to describe their process, which could potentially have dual translations in Spanish. One example of this was the use of the word "compromisos" which in Spanish and English represent a nuanced set of meanings.

Additionally, throughout the collection of data I worked to document analytic memos and diagrams that enhanced my interactions with the data by representing it, making comparisons, posing questions, coming up with concepts, and suggesting possible relationships between the themes and codes (Corbin & Strauss, 2015). As I immersed myself in the data and the reciprocal

data analysis, the record keeping of these mental processes also extended to the use of reflexive journals that allowed me to document my personal experience and the impact of this research on my own process (Corbin & Strauss, 2015; Hays & Singh, 2012).

I also used triangulation by utilizing diverse forms of evidence to support and better describe findings (Hays & Singh, 2012) and to increase the credibility of the results (Lincoln & Guba, 1985). Specifically, I worked to triangulate data sources by including multiple perspectives to enhance my understanding of the participants' descriptions (Hays & Singh, 2012). Hence, this study included two rounds of interviews and two rounds of member confirmation interviews, or interpretive dialogues, in order to enhance participants' triangulation of the data. In each of these points of contact with the participants, I made sure they were informed of the evolving analysis process, so that they could expand, confirm, and refine the emerging codes and analysis.

I further triangulated the sources by integrating the perspective of an external auditor who determined the extent to which the emerging analysis represented a comprehensive and rigorous portrayal of the participants' descriptions (Hays & Singh, 2012). Moreover, in order to honor the importance of descriptions grounded on lived experience and the unparalleled value of first account narratives of disabled people (Charlton, 1998; Olkin & Pledger, 2003; Reeve, 2000, 2006), a licensed professional counselor who has lived for twenty years with a physical disability was recruited and consulted as a final step in the analysis process. Lastly, and as evidenced in the description of the emergent grounded theory in the previous section, I used theoretical triangulation to understand, frame, and present the participants' descriptions on the existing literature on the research gap (Hays & Singh, 2012).

I also engaged in peer debriefing as an additional strategy for credibility of my qualitative conclusions. Peer debriefing sessions with my advisor, Dr. Nicole R. Hill allowed for another check to challenge my understanding of the participants' experiences and the emerging findings (Hays & Singh, 2012). Peer debriefing with Dr. Nicole R. Hill also afforded me the opportunity to test working hypotheses that continuously emerged in my process of memo and journal documentation (Lincoln & Guba, 1985). Thus, through documentation, triangulation, and peer debriefing, I consistently strived for a contextualized and dependable description of my participants' experiences related to their development of disability counseling competence as licensed professional counselors.

In terms of transferability, I consistently worked to obtain, capture, and document thick descriptions and rich narratives of the participants' contextualized experiences to help future readers make decisions about the degree to which these findings are applicable to their work (Hays & Singh, 2012). As it can be observed in the chapters pertaining to the participants' interviews (Chapter IV-VII), I worked to offer participants' detailed and meaningful descriptions of the topics discussed in each interview. In terms of dependability, I strived for the co-construction of the descriptions and final results by reaching interpretive consensus with the participants and research team throughout the analysis process, as well as the external auditor at the end of the research process. This strategy helped me ensure trustworthiness related to the consistency of the emerging analysis across time and across the parties involved in the co-construction of this grounded theory (Hays & Singh, 2012; Lincoln & Guba, 1985).

Finally, in terms of comfirmability, I actively engaged in the use of member checks where the participants and external auditor reviewed the data, analytical categories, and emerging conclusions (Hays & Singh, 2012). The use of member checks in the form of interpretive

dialogue interviews provided opportunities to assess intentionality in the narrated descriptions, adjust the representation of experiences, and confirm the adequacy of the participants' descriptions (Lincoln & Guba, 1985). Moreover, the interpretive dialogue interviews increased comfirmability of the findings as participants described how well the emerging analysis represented their experience of development of disability counseling competence (Hays & Singh, 2012). For instance, the participants continuously commented how the emerging analysis reflected their experience accurately.

In summary, my study's trustworthiness was considerably enhanced by my ability to integrate strategies for credibility, transferability, dependability, and comfirmability. Specifically, I consistently engaged in strategies that guaranteed my continuous immersion in the data, documentation of emerging analytic connections through memoing, triangulation, and the substantiation of assertions through consensus reaching in peer debriefing sessions with my advisor, Dr. Nicole R. Hill. Moreover, as researcher of color, I strived to remain reflexive and aimed to produce and describe an emerging theory fundamentally grounded on the participants' descriptions but that is also informed by my positionality. Lastly, these efforts for trustworthiness ensured the emergence of research implications that can be used by future readers.

The implications drawn from the emergent findings can be applied to counselor preparation programs, counselor educators, clinical supervisors, and professional counselors. In the next section, I will expand on the particularities of the potential use of these implications. I will also recommend action steps for further programmatic adjustments and research considerations to enhance the current knowledge base of counselor's development of disability counseling competence. Furthermore, some of these implications include participants' excerpts in order to

foster a powerful approach to substantiate my recommendations and enhance future readers'

applicability of participants' insight into the changes needed in their profession.

Implications and Recommendations of the Current Study

This study sought to illustrate the processes and dimensions involved in licensed

professional counselors' development of disability counseling competence, and in that attempt,

the participants' narratives afforded the elucidation of multiple potent implications for the future

of the profession. The implications to be presented in this section pertain to different areas of

professional practice. Specifically, these implications are applicable to training programs,

clinical supervision, clinical practice, and professional organizations.

Counselor Training Programs Implications

As mentioned in Chapter II, training programs have the responsibility of training

counselor well versed in multicultural issues, and who are prepared to affirmatively work with a

variety of multicultural populations (Arredondo & Toporek, 2004CACREP, 2016; Ratts &

Pedersen, 2014). Moreover, given the increased recognition of demographic changes in the U.S.

(Brault, 2012), there are increased demands for counseling programs to be responsive to these

changes by training counselors able to work with multiple populations, including the population

of clients with disabilities. The findings of this study can significantly inform counseling

programs inasmuch as this grounded theory has emerged directly from licensed professional

counselors who graduated from these programs and are now working with clients with

disabilities. Thus, counselor education programs can utilize the implications and

recommendations emerging from this study to enhance the representation of disability, instill

counselor awareness, and disrupt simplified and essentializing descriptions of disability within

training.

The majority of the participants recognized the ***systematic silence of disability*** within the category of **Systemic Dimensions** that impacted their development of disability counseling competence. The participants recalled having minimal or limited experiences in their training programs where the generation of discussions around disability issues would enhance their level of understanding related to the complexities of the work with these clients. Specifically, participants commented on their minimal experience of getting disability lectures on the core area of Social and Cultural Dimensions of Counseling (CACREP, 2016) that was reflective as a single-population approach in their multicultural class (Pieterse et al., 2009). For instance, Allison described the need for programs to move beyond a single class focus and intentionally integrate class contents related to government benefits related to disability and their relationship with the role of a mental health counselor. Allison excerpt highlights the need for more training in disability issues within the counseling program.

> ALLISON - And I think what it comes down to is maybe it's not a cold class on disabilities but maybe just two courses about disabilities. What is a disability? How do you know someone's disabled? I mean, again, you're filling out this paperwork for people and it's like, "I don't know." It's like a whole new world.

Training programs can introduce the overall model emerging from this study in the multicultural course to highlight the process of multicultural competence development related to disability, instead of covering disability in one only class. Moreover, instead of limiting disability lectures to the multicultural class, training programs could foster enhance multicultural competence by integrating disability content into other core areas of counselor training. For example, faculty can actively integrate systemic dimensions of disability within a variety of courses (i.e., professional counseling orientation and ethical practice, counseling and helping

relationships, assessment and testing, and psychodiagnosis) to highlight the social complexities that surround disability. Faculty can further use participants' excerpts emerging from this study to be stimulus narratives for students' reflection on systemic dimensions of the counseling work.

Training programs could also foster disability representation in the curriculum by defining more intentional and systematic learning objectives pertaining to disability considerations. For example, for each of the required CACREP courses, rubrics of assignments can include the applications of contents to the population of clients with disabilities. The representation of disability contents can be also secured in summative evaluations such as clinical capstones and comprehensive examinations.

Another issue related to the ***systematic silence of disability*** identified by the participants was the lack of representation of disability in the counseling student body, in classroom materials and research used in the classroom, as well as in faculty. If training programs intentionally emphasize the use of inclusive research as part of the training materials, or if they systemically adopt a more critical stance and questioned the silence of disability in the materials used, they could foster students' ability to notice the lack of representation of disability in and out of training. For this, faculty can guarantee the inclusion of first account narratives from people with disabilities in the use of vignettes and case examples in foundational classes (i.e., ethics and professional dispositions, human development). Also, faculty can assign readings and assignments aimed to critically analyze diagnostic categories and the representation of persons with disabilities in popular culture. As demonstrated in the emergent grounded theory, counselors' realization of the ***systematic silence of disability*** played an important role in their development of disability counseling competence.

Training programs could add this dimension of identity to their recruitment efforts in a way that strives for inclusive admission processes that are more accurately reflective of the demographic make up of the area. Training programs can intentionally build collaborative partnerships with disability centers in colleges and universities, in order to more actively extend the opportunity for applying for a counseling program to wider community. For example, each Spring, counseling programs could sponsor outreach events where current counseling students and faculty deliver information sessions and attract prospective students in disability centers in colleges and universities. These suggestions are congruent with Moreover, Shin et al. (2011), who recommended increasing the representation of persons with disabilities and other marginalized identities in CACREP accredited programs.

An additional way in which counseling programs can disrupt the ***systematic silence of disability*** and connect with the ***client's community*** is by intentionally generating opportunities within different courses to host guest speaker sessions where disabled people (i.e., clients, professionals) share their unique experiences and perspectives. As mentioned by Queen, partaking in the visitation of a guest speaker who is an activist and member of the disabled community provided her with a different and insider perspective of the power of mental health knowledge and labels. Training programs can actively reach out to the disabled community and build coalitions that would benefit both parties.

Moreover, some participants in this study mentioned difficulties in initiating contact with the ***clients' community***. Counseling programs can facilitate students' connection with the community of people with disabilities by including assignments that extend beyond the classroom and include their interactions with the students' overall community. For instance, faculty can include assignments such as community mapping and advocacy projects.

Furthermore, counselor training programs have the responsibility of supporting the development of students' multicultural competencies to embrace diversity and work with any population (Arredondo & Toporek, 2004; Hill, 2003; Matthews-Juarez & Juarez, 2011; Ratts & Pedersen, 2014; Watt et al., 2009; Wilkinson, 2011). Moreover, as a training standard, CACREP (2016) compels counselor education programs to emphasize students' self-exploration and awareness of potential biases and ***negative attitudes***. As reflected in the emergent grounded theory, the dimensions of ***reflexivity***, cultivation of ***consciousness*** through ***personal work***, and the ***understanding and use of privilege*** were highly emphasized within the participants' perceived development of competence.

Throughout the study, a few participants consistently used offensive language and expressed problematic views and actions that showcased the dangerous and ableist exclusion of an entire group of people. These problematic views and actions of some of these participants related to denying services to certain clients based on a diagnosis. Training programs can actively address these biases by fostering students' awareness of biases and assumptions related to disability through the use of attitude measures related to disability when students encounter a client with disabilities in their internship practice. Internship instructors can further use the overall model emerging from this study to normalize students' reactions and illustrate the process of development that follows the recognition and processing of these initial attitudes and reactions. Counseling programs can also address these problematic views and actions through the use of case examples and vignettes to be deconstructed and processed in the Ethics class while guiding these class discussions with the ACA's *Code of Ethics*. Lastly, counseling programs can illustrate the power of counselor reflexivity in the development of multicultural competence by

using participants' excerpts emerging from this study to motivate students to move beyond these initial attitudes and reactions about people with disabilities and other multicultural groups.

Additionally, participants in this study expressed that by ***understanding and using their privilege***, their level of empathy and disability consciousness developed. Counseling programs can integrate narrative pedagogical approaches (i.e., autobiographies) into required courses in order to evoke attitudes and reactions described in this study and further foster counselor reflexivity, enhanced empathetic understanding, and potentialized multicultural consciousness. Furthermore, counselor training programs can actively engage students in the examination of their power and privilege in class discussions as well as enact their power for advocacy as mental health counselors. Counselor training programs can accomplish this by systematically integrating these critical conversations as part of the classes, as well as assigning advocacy projects aimed to meet accreditation standards and demonstrate learning outcomes related to the use of their privilege as able-bodied counselors, if this is the case.

Additionally, results emerging from this study indicate the juxtaposition of counselor reflexivity and self-initiation in their ***ethical decision making*** process related to serving clients with disabilities. Counselor preparation programs can integrate the ethical decision making model emerging from this study in the ethics curriculum to highlight the commitments involved in counseling professional practice. For instance, this ethical decision making model can be used as a case-based analysis in clinical courses to emphasize students' ethical reasoning when making service decisions with clients with disabilities. This ethical decision making model can also be used as a stand alone model to be used in clinical practice.

Also, training programs can foster faculty's attentiveness to students' comments and attitudes indicative of potential biases related to the population of clients with disabilities in

order to generate consultation meetings in conjunction with other faculty where these negative attitudes are addressed. Moreover, if these negative attitudes are part of the student's review at the end of each semester, faculty can use disability literature to enhance the discussions and ground them in the realistic criteria of disability counseling competence needed for the work with clients with disabilities. This emergent theory is one example of that disability literature. Counselor preparation programs following these implications related to addressing awareness could avoid problematic student dynamics that would inform avoidance and lack of interest to clinical opportunities involving clients with disabilities.

Moreover, counselor preparation programs must address students' negative attitudes as these can significantly impact the counseling relationship in internship experiences and after graduation. One way to do this can be the active integration of clients with disabilities in initial clinical courses such as pre-practicum. In this way, students can receive peer and faculty feedback and enhance their self-awareness about the impact of their own reaction on the counseling relationship with their initial clients. A final implication related to counselor training programs' intention to address negative attitudes and enhance counselor self-awareness related to disability could be the systematic use of inventories aimed to examine applicants' attitudes around disability during the admission process. Having this information can significantly inform the admission process and the program's understanding of the student's learning and personal development demands. By implementing these recommendations, training programs could address the internalized negative values about people with disabilities that can heavily inform counselors' competence in working with this population.

Finally, counselor education programs can significantly work to disrupt simplified and essentializing descriptions of disability within training. Within the emergent grounded theory,

the participants expressed the need to ***recognize disability as cultural group*** as a fundamental part of their development of disability counseling competence. The recognition of disability as a cultural group entails the acknowledgment of systemic dynamics informing this identity, such as prejudice and stigma, history of oppression and discrimination, as well as the recognition of the unique aspects of disability as an identity. This analytic component further expands the individual focus of disability and integrates social and historical factors related to this identity.

Counselor training programs can infuse theoretical foundations and historical perspectives of disability throughout counselor curriculum. For instance, as Queen suggested, programmatic contents in different classes (i.e., professional orientations and ethical practice) can include topics such as disability rights movement and the historical changes related to policy and accommodations that inform the counseling profession's understanding of the work with clients with disabilities. Also in clinical classes, faculty can actively integrate different ways of thinking about disability when examining and discussing students' conceptualization of the cases that are presented in group supervision. For example, instructors can request students to write client conceptualizations from the medical and social model of disability.

Counseling programs could also develop programmatic designs that would afford students that opportunity to take a course focused on disability counseling competence. This course could include content related to the pervasive problematic portrayal of disability in society and its direct impact on the counseling profession, the impact of oppressive systems in the lives of disabled clients, the ethical commitments that surround a socially responsive counseling practice, and skills and interventions to engage and work with clients, families, and communities where disability is represented. Moreover, this course could be of experiential

nature so that students can learn while confronting their biases, while being supported by faculty and their peers.

Furthermore, the findings from this study suggest the importance of integrating the impact of **Systemic Dimensions** that inform the counselors' **Therapeutic Work** with clients with disabilities. For instance, based on the analytic theme of ***double bind***, one way in which counseling programs could contextualize this is by presenting SSI paperwork examples during conversations about clients' wellness, treatment progress, and resiliency. Counseling programs can also present the overall emerging model from this study during clinical courses in order to generate discussions related to the impact of systemic dimensions in their perceived development of competence. Lastly, counseling programs can initiate more explicit discussions of managed care, third party reimbursement, and access to services in the mental health curriculum.

The findings from this study can significantly inform training programs' attempts for enhancing the representation of disability, instilling counselor awareness, and disrupting simplified and essentializing descriptions of disability within training. Moreover, this emergent grounded theory could be used by counselor training programs as a theoretical framework for the examination of the training needs pertaining to disability counseling competence. Additional implications for clinical supervisors within the profession are described in the next section.

Clinical Supervision Implications

The participants widely highlighted the importance of community in their work as professional counselors and in their development of disability counseling competence. Specifically, through the category **"It Takes a Village,"** the participants illustrated the substantiality of their professional and learning communities in their process of development. Within their professional communities, the participants expressed the value and support of

collaborative relationships with supervisors who provided information, encouragement, mentorship, and promoted personal development. These participants' assertions are corroborated by Bernard and Goodyear (2014) and Neswald-McCalip (2001) who have conceptualized supervision as the space for learning, guidance, development, and interpersonal productive working alliance. Therefore, based on the findings of this study, several supervision implications can be illuminated. Specifically, clinical supervisors can utilize the implications and recommendations emerging from this study to enhance the supervisees' collaborative relationships, foster supervisees' reflexivity, and support supervisees' navigation of systemic demands for productivity.

For the participants in this study, supervision in their place of employment was the space for consultation with their professional community in order to enhance learning, personal development, and obtain guidance for the utilization of counseling interventions with clients with disabilities (Bernard & Goodyear, 2014). Even though the participants did not significantly emphasize the evaluative dimension of the supervisory relationship, they certainly highlighted the potential of nurturing working alliances that represented support and development in their own process.

Supervisors in counselors' site of employment can deepen their commitment for supervisory relationship and intentionally integrate supervisory activities aimed to foster the interpersonal and ***collaborative relationships*** with counselors serving clients with disabilities. For instance, reserving time for personal interactions and relational interchanges with their supervisee besides the consistent consultation of cases and site procedures (i.e., record keeping, documentation, paperwork), supervisors can enhance the strength of the relationship and represent a secure base of consultation and support for professional counselors. By establishing

working agreements, clarifying expectations, and meeting regularly, supervisors can enhance the quality of the working alliance and further support these counselors. Furthermore, being that clinical supervisors might even represent professional counselors' point of access to the extended professional village for enhanced *collaborative relationships*, another recommendation for supervisors could be to include this study's analytic theme of *Circle of Trust* and *Expertise* into the supervisory work. This could assist supervisees in identifying different aspects to the various domains that work for them, or developing an action plan how to achieve them in their extended professional communities.

Another area involved in counselors' development of disability counseling competence is the engagement in self-reflection and unpacking of privilege for increased awareness. As observed in the emergent grounded theory, counselors' ability to *understand and use their privilege* in the mental health system significantly informed their disposition to take risks, remain open and flexible, and deepen the alliance with their clients. Supervisors can further support supervisees' development in these areas by highlighting self-reflection as an important part of the supervisory process and modeling reflexivity for the supervisee. Furthermore, while grounded in a supportive supervisory alliance, supervisors could further name and challenge supervisees' potential negative attitudes and reactions that significantly impact the work with their clients with disabilities. For instance, one activity that supervisors can integrate is the supervisee's completion and processing of an inventory that measures the counselor's attitudes around disability. With this objective measure, the supervisor can encourage the supervisee to honor the professional **Evolving Commitments** for reflexivity and development, position this development as a professional goal, and further contrast different measures of the same instrument across time.

Participants in this study also highlighted the importance of a flexible and creative approach to the work with clients with disabilities that informed their intention to affirm and embrace diversity in their *counseling focus*. Being more experienced and having increased access to other domains of information in local agencies (i.e., client issues, institution's goals, financial planning), supervisors can further support their supervisees' development of disability counseling competence by recommending internal alliances and consultation with other professionals within the institution, or suggesting meaningful trainings in the *learning community*. For instance, supervisors could design and deliver monthly collaborative consultation group sessions between counselors and case workers to discuss social needs experienced by clients with disabilities (i.e., housing applications, Medicaid Service Coordination).

Given the *systematic silence of disability* in institutional trainings, supervisors can also advocate for the inclusion and representation of disability in seminars, workshops, and professional development requirements within the institution. Furthermore, supervisors can recommend supervisees to attend professional development opportunities related to expressive arts and narrative trainings in order to enhance the repertoire of interventions of counselors working with clients with disabilities.

Finally, as illustrated in the emergent grounded theory, the dimension of *productivity within mental health systems* was considered a **Systemic Dimension** that impacted the counselors' development of disability counseling competence. Supervisors who are in charge of assigning caseloads and informing the productivity demands for counselors could initiate meaningful conversations with their supervisees, individually or in group supervision, in order to validate the counselors' level of investment in meeting these demands and emphasize the

importance of self-care and wellness in the job place. Moreover, supervisors could further use their power in the system to advocate for their supervisees' needs at the managerial and administrative level. For instance, they supervisors could advocate for productivity adjustments when working with some clients with disabilities, as well as for expanded processes related to documentation and treatment planning. Additionally, supervisors could advocate for local agencies and schools to allocate resources for art supplies to be used in interventions through expressive arts with clients with particular disabilities, instead of expecting counselors to cover the expenses of those therapeutic materials. Even though not all clients with disabilities might need extended times for achieving treatment goals or require different approaches, clinical supervisors can advocate for extended assessment periods where counselors can better understand and identify the clients' needs.

This study's findings can significantly inform clinical supervisors' efforts to enhance the supervisees' collaborative relationships, foster supervisees' reflexivity, and support supervisees' navigation of demands for productivity. Moreover, clinical supervisors can also present this emergent grounded theory as a guide for the different learning aspects involved in the development of disability counseling competence of their supervisees. Additional implications for the clinical practice of counselors are described in the next section.

Clinical Practice Implications

The participants in this study strongly recognized different aspects involved in their clinical work with clients with disabilities. These aspects were encompassed and described in the category of **The Therapeutic Work**. Participants highlighted the importance of remaining flexible and creative when tailoring the approach to meet the individualized needs of their clients with disabilities. The clinical implications for counselors' therapeutic and multicultural skills

area related to their ability to plan, conduct, and implement a variety of multicultural approaches aimed to assist the clients in processing their experiences and meeting their counseling needs (Ratts & Pedersen, 2014). Moreover, additional implications related to the counseling relationship and advocacy opportunities are presented in this section.

Overall, the participants described the importance of meeting the clients where they are at in their psychological process, independently of their disability. Thus, an implication emerging from this study could inform the counselors' possibility of creating lists of open ended questions for their initial interviews with clients aimed to explore internal psychological processes of meaning making, development, and resiliency. By doing this, professional counselor can increase their level of preparation for the initial contact with clients who represent an identity with which the counselors might not have much experience.

Also, the participants described the importance of remaining creative and open to new ways of connecting with their clients to assist them in their process. For instance, Tela mentioned the use of bibliotherapy and self-help books in the work with clients with disabilities, as a way to mediate the counseling process with additional tools that the client can take home, read at their own pace, and process on the following sessions. Even though this suggestion assumes the client's ability to read and the possibility to obtain the written materials, counselors can articulate their resources by *self-initiating* and connecting to their *professional and learning communities* in order to find additional materials that are better suited for different levels of ability (i.e., in a different language, illustrated books, close captioned materials). Moreover, Tela further extended this recommendation for counselors' self-care.

TELA - I think that bibliotherapy has been shown in a lot of research to be as effective as therapy. I think that a lot of people whether they give that direction through seeing a

therapist or just on their own, for patients it's great and also for counselors, professional development kind of goes into each of those. Like if I or anyone else needs to learn about a new approach or trying to build competence, we might go to a training but we're more likely to read a book on it depending on our location and those kinds of things. And also I think for patients, bibliotherapy can be just hugely helpful and have a large impact.

Along with the recommendation for increased openness and flexibility in tailoring the approach to the work with clients with disabilities, the emergent grounded theory in this study affords further implications for professional counselors in navigating the tensions of the ***counseling focus***. First, the participants widely highlighted the significance of the counseling relationship in their development of disability counseling competence. For them, the ability to cultivate and enhance the relationship with their clients afforded them opportunities for getting to know their clients, their stories, and the intricacies of the disability identity in their overall experiences. Professional counselors could further enhance and potentialize the ***counseling relationships*** with their clients by openly recognizing and embracing the dimensions of experienced oppression, stigma, and discrimination that people with disabilities experience in society. By enacting this affirmative approach, clients can feel more encouraged to openly define the goals for their treatment as well as their expected outcomes from the counseling relationship. This open and genuine approach can represent meaningful opportunities for collaboration and deepening of the working alliance over time.

As counselors reflect on the power they represent in their immediate professional community and engage in self-reflection aimed to enhance their ***understanding and use of privilege***, counselors can extend their clinical work beyond the boundaries of their office and use their clinical skills to reach a greater audience in local agencies and organizations. Moreover, as

the counseling profession has maintained growing commitments for social responsibility and human dignity by repositioning multiculturalism at the core of counseling pedagogy, practice, and research (Ratts & Pedersen, 2014), counselors can attend to the different implications emerging from this study by potentializing their community-based engagement. For instance, professional counselors working in community agencies, schools, and higher education can design, organize, and deliver group presentations aimed to educate the larger community about clinical issues pertaining to disabled clients and students and their families. Moreover, counselors can use their position in the system and advocate for access and inclusion of clients with disabilities. For instance, in staff meetings and IEP meetings, professional counselors can use their knowledge and interpersonal skills to educate these communities about the importance of wellness, resiliency and development of clients with disabilities, and further advocate for service accommodations.

Additionally, the emergent grounded theory illustrated **Systemic Dimensions** that impact the counselors' development of disability counseling competence and that influence a profession that further creates disability. In other words, professional counselors have to handle system's *fantasies of cure* that seek to standardize and objectify the therapeutic process through measurable goals, treatment objectives, and interventions aimed to quantify and document client progress, while also being part of a system that reifies the medicalized construction of disability and the perpetuation of cure as the only viable solution.

Human distress is further conceptualized as something to be fixed through biological approaches that are a legacy from psychiatry (Mills & Fernando, 2014) where clients are considered to have disordered lives as a sign of pathology that needs to be immediately eliminated through clinical interventions (Hansen, 2016). Thus, the counseling profession bears

the weight of Western narratives of efficient curing that promotes the questionable ideas of quick

and painless purchasable solutions. Examples of these are short-term evidence-based practices

and the use psychotropic medication to treat symptoms of human distress (Ingleby, 2014). These

Western forces within the counseling profession and other mental health professions have

become institutionalized as central and unquestionable. Moreover, these forces result in the

intentional acculturation into ideas of objectified mental health that are reified through the use of

diagnoses, and that further contribute to the creation of impairment and disability within America

(Meekosha, 2011).

Professional counselors could greatly benefit from engaging in reflexive practices aimed

to develop their critical thinking about how these systems' fantasies of cure can be detrimental

for clients. Furthermore, as counselors navigate and meet these systemic demands for

documentation and the use of evidence-based practices, they can remain grounded in their

commitments for honoring the counseling engagement that represents wellness, relationality,

resiliency, and community. For instance, counselors can generate honest discussions with clients

and position these demands as part of the work but not the central aspect of the therapeutic

encounter. They can also arrange a specific set of time in the counseling session for the

discussion and client's approval of treatment plans, while prioritizing the client's expression of

their experiences and processing of feelings.

Furthermore, the counselors expressed their level of resonance with others' experiences

and excerpts through the interpretive dialogue interviews. The participants asserted that reading

others' comments and connection to the analysis made them feel normalized and validated in

their own experiences. As evidenced in this study, these perspectives may have more universal,

than particular elements. For instance, Unice expressed her appreciation for being able to read others' scenarios and, along with Allison and Jen, highlighted the commonality of their struggles.

UNICE - It was validating. It was interesting because it brought up some things that perhaps I had not thought of but it was very comforting to me to know that others, other clinicians, have similar scenarios and that some of the struggles were very common. Because again, in this environment if we don't have the opportunity to share our thoughts and feelings with other professionals sometimes it can be a frustration making us feel, "Could it be something that I'm not doing properly or is it something that I might have missed?" I'm glad that the focus is being brought into this environment working with clients with disabilities and some of the competence struggles that we might encounter. I did enjoy reading it, so I thank you for that.

ALLISON – I can see that I'm not alone with everything, in what I think, and so that's really cool.

FAITH - I think looking at the diagram that you've done and reading this information, I think it's done. It's just so interesting to me to see everything and everybody else's comments. I think your diagram really helps put it all into perspective with everything that you've heard from talking to all of us. I just think it's really interesting.

Senior counselors working in clinical settings could use some of these excerpts or generate new opportunities to obtain peer perspectives in order to validate new clinicians' process.

Also within the ***counseling focus***, the participants also expressed the commitment for honoring their intentionality to embrace difference by following the client's lead when defining the goals for treatment. Counselors can actively embrace the client's identity by genuinely supporting their needs in the therapeutic context and measuring progress according to the clients'

metrics. Also, counselors can further potentialize their enactment of ***disrupting practices*** by advocating for their clients' needs in their local agencies. For instance, every other month, counselors can check in with clients and explore the specific ways in which the clients expect their needs to be met not only by the counselor, but by the greater professional community. From here, counselors can communicate these expectations to supervisors and propose action steps to create the change the clients expect to see. Thus, as professional counselors develop competence to navigate the ***counseling focus***, they have the potential for delivering services that are embracing, affirmative, and aligned to the clients' goals for treatment.

In short, this emergent grounded theory has afforded some practice implications and recommendations that can be implemented by professional counselors working with clients with disabilities. These practice implications are mainly related to flexible approaches, the counseling relationship, advocacy around disability issues, and affirmation of client's identity in the counseling work. The following sections highlights implications related to professional organizations.

Professional Organizations Implications

As previously mentioned, the participants recognized the ***systematic silence of disability*** in their training programs and professional ***learning communities***, which also included professional conferences. The emergent grounded theory can significantly inform powerful implications to be implemented at the professional organization level. Specifically, professional counseling organizations can utilize implications emerging from this study to further disrupt the absence of disability, enact impactful leadership related to disability issues, and address internal disconnections within the profession.

Participants commented on professional conferences as part of their learning communities, which they attend for networking and professional development, and where disability contents are also absent in the presentations offered. Professional organizations can more intentionally engage in endeavors to increase disability representation in the education sessions and other presentation formats within professional conferences. For instance, professional conference organizers can stipulate a panel inviting counselors to share their experiences related to their disability counseling competence. Moreover, professional counselors can get organized and create a white paper with persuasive, authoritative, in-depth arguments related to the absence of disability contents in professional conferences, and provide solutions such as division-based presentation slots to be used for disability-specific contents. Furthermore, conference organizers can stipulate themed poster sessions (i.e., clinical issues surrounding physical disabilities, resiliency and developmental disabilities) or pre-conference retreats to offer an opportunity for counselors to process the impact of **Systemic Dimensions** in their work with clients with disabilities.

Additionally, in order to honor the professional commitments for multiculturalism and social justice (Ratts & Pedersen, 2014), professional conferences can systematically warrant accommodations for counselors and educators with disabilities that go beyond ramps. For instance, sign language interpreter can simultaneously interpret education sessions and handouts can be made accessible in multiple formats for different levels of ability. The results emerging from this study suggest that the efforts for inclusive practices within professional organizations need to emerge from members, divisions, and leaders within professional counseling associations.

Participants reflected on the ***systematic silence of disability*** that also pertains to leadership representation within professional organizations. For instance, Jerome expressed the need for intentional leadership to emerge within ACA in order to deliver a clear message about the relevance of disability issues. Jerome described this in the following manner.

JEROME - The only thing that I thought about recently is the need for strong leadership. I think when you don't have strong leadership on certain topics, these topics don't get valued, whether or not it is disabilities, whether it is LGBTQ rights, whether it's self-work of a therapist, whether it's anything, any topic in mental health. I think that if there is not a strong leader who can direct what people need to do, then I think the message gets cloudy, and then the expectation is that people are going to work on their own, or value that on their own, and that doesn't happen. If you are a strong leader that says, "We really need to focus on disability competence, and we're going to do a good job at doing that," tends to be that will happen, but if you don't have a strong leader that is going to make that happen and follow up with it and hold people accountable, then that won't happen. If an organization really wants to push it; say, ACA wants to push disability competence, then they need to be on it. They need to do many, many, many, many things. The bigger you are, the more you need to do.

As described in Chapter II, the counseling profession has historically enacted social responsibility and multicultural commitment at the association level. For instance, the launching of AMCD endeavored for the inclusion of marginalized identities in the counseling practice and discourse (Arredondo & Toporek, 2004; Ratts & Pedersen, 2014) and the enactment of leadership to assist the counseling profession in recognizing the value of social identities as indelible dimensions of every human being (Arredondo & Toporek, 2004). The creation of this

organization within ACA responded to antecedents of scientific racism within counseling such as the historical misrepresentation of minority identities in counseling research, counseling and therapy texts, clinical training, and leadership positions (Arredondo & Toporek, 2004; Ratts & Pedersen, 2014).

Thus, in congruence with professional commitments for multiculturalism and social justice (Ratts & Pedersen, 2014), professional organizations could attend to a variety of implications emerging from this study. Professional organizations such as ACA could advocate for the systematic (i.e., annual, biannual) publishing of special issues related to the clinical work around disability in the major journals in the counseling profession. Moreover, disability can be more intentionally represented in the annual conference theme that is advertised nationally. Furthermore, ACA could more actively use public communications (i.e., listservs, mailed magazines) to emphasize the work of the counseling profession pertaining to disability issues. For instance, just as ACA has stood up for LGBTQ rights, ACA could bring more visibility to injustices and human right violations against the disabled community.

Finally, the participants did not actively consider the community of rehabilitation counselors, or the ARCA as part of their professional community. This is congruent with Smart and Smart's (2006) assertions of disability issues being a topic exclusively reserved for rehabilitation counselors. For instance, Cortina expressed initial disengagement and professional compartmentalization of rehabilitation issues as a licensed professional counselor, whereas Jerome described his experienced divide between professional territories.

> COTINA - I think partly then I feel like I don't have to get more training for it because there are people that do it, which help it. But then I feel like, well that's a specialty working with people with disabilities. So maybe I should not do it as a counselor. And I

don't know how to make sense of that because on one hand being trained as a counselor, I feel like we're taught to be able to work with a diverse population, you know, which includes people with disabilities, which is what I've done in my experience, is worked with anyone really. And then now knowing like well there is actual rehab counselors and there is a specialty in it, that maybe the people with disabilities would be more helped by rehab counselors or those like different programs.

JEROME - That's the thing. I don't know. The same thing: I imagine; I don't know. I don't know what rehabilitation counselors exactly do. I have no idea. I think that is the problem, is that there is […] I think that part of the other issue that happens is that there is this schism between different mental health professions. Everybody is trying to eke out some territory in the corner. I don't know what rehabilitation counselors do. I think they do rehab of some sort. That's all I can tell you. I know more about what social workers do. I know more about what marriage and family therapists do, but I'm not part of their organizations, because not a lot of organizations want to be together. They all want to have their own separate identities.

Additionally, counselors' potential disengagement of disability and rehabilitation issues is dimensionalized by their described confusion around the boundaries that define ***disability as an identity***. For instance, some participants expressed the hesitance to define disability as merely physical, sensorial, cognitive and developmental, and extended it to mental health conditions, substance abuse and alcoholism. Moreover, participants considered all these disabilities as these conditions also led to client's receiving government disability entitlements.

ACA's 20/20 initiative for the future of the counseling profession has stipulated as one of the main goals the profession the achievement of a unified professional identity (Kaplan &

Gladding, 2010). It is alarming that at this point, three years from 2020, professional counselors still experience confusion about the group of people they serve, as well as internal divisions within the profession that impact development and multicultural competence. Even though ACA has legitimized the rehabilitation discourse in many realms of the counseling profession through the creation of the ARCA, the internal disconnections within the profession represent a disservice for professional counselors' opportunities to access the greater professional community. These internal divisions have further informed some counselors' detachment from disability issues, given that counselors have felt these issues not pertaining to their realm of clinical practice and competence.

Thus, given that disabled clients who seek counseling services might not distinguish between counseling specialties, it becomes urgent that ACA takes steps for building internal linkages between professional territories and enhance the possibilities for professional counselors' development and professional collaboration. In this sense, ACA could more actively link disability issues to its main discourse within the profession instead of circumscribing it to ARCA's ground of action. For instance, ACA can launch a disability interest network for professional counselors pertaining for different associations to partake and interchange questions and ideas related to the clinical work with clients with disabilities. Moreover, given the merge between CORE and CACREP, the increased representation of rehabilitation contents within CACREP programs could decrease the participants' reported distance between their clinical ground of action and disability or rehabilitation issues. Therefore, professional organization can benefit from implementing implications emerging from this study in order to disrupt the silence of disability, enact impactful leadership related to disability issues, and address internal disconnections within the profession.

This emergent grounded theory is a particular version of the many potential illustrations of the participants' experiences of development of disability counseling competence. However, I anticipate that the implications and recommendations that have emerged in this chapter will enhance the collective response to disability issues within professional counseling. In the next session, I will expand on recommendations for future research endeavors aimed to enhance the knowledge base of disability counseling competence in the practice of licensed professional counselors. The next session will also expose several limitations encountered in this study.

Limitations and Recommendations for Future Research

The emergent grounded theory presented in this chapter is a comprehensive interpretation of licensed professional counselors' process of development of disability counseling competence. Throughout the research process, I engaged in multiple strategies to ensure trustworthiness and credibility of this study's results. Specifically, I engaged in meaningful and analytic documentation through memos and journals, challenged and refined my emerging conceptualizations in collaboration with Dr. Nicole R. Hill through peer debriefing, and triangulated the data and the sources of information. For instance, the emergent grounded theory was substantiated by the counseling literature and was also refined and confirmed by the participants in the interpretive dialogue interviews. Implications for counselor preparation programs, clinical supervisors, professional counselors and counseling associations have been identified, as well as several opportunities for the expansion of these findings through future research. These potential areas of expansion of the current emergent grounded theory are presented next.

As mentioned in Chapter III, I had the intention to recruit a diverse group of licensed professional counselors that represented a variety of cultural identities. The final sample of

twenty participants represented 10 percent of racial variation (18 Caucasian and 2 Latina), 20 percent of gender identity variation (16 Female, 3 Male, and 1 Gender Queer), 15 percent of language variation (17 participants identified English as their primary language used as a counselor and 3 identified the use of Spanish as well), and 35 percent of the participants self-identified as having a disability or had temporary disabled conditions in the past. Even though some internal variation pertaining to the counselors' personal impact of having a disability was identified and integrated in the analysis, no major analytic observations emerged from racial, gender identity, or language differences in the group of counselors. Future research efforts could examine the influence of identity variation in the understanding of disability and the development of disability counseling competence. Such future research could further illuminate the differential trajectories of the development of disability counseling competence as these trajectories are informed by the social identities of the counselors.

Moreover, this study included 19 participants who lived and worked in the Northeast region of the country, whereas 1 participant resided in the Southern region of the country. The homogeneity of this demographic variable within the sample could limit the understanding of the development of disability counseling competence, as it is mainly referred to the northeastern region of the country. Future research could include enhanced variation of this demographic variable in order to illuminate potential differences in the development of disability counseling competence in other regions of the country. Specifically, future research could explore the impact of local availability of mental health services and state-specific licensure and reimbursement laws on counselors' development of disability counseling competence. Additionally, increased sample sizes could afford a more pronounced variability of the representation of social identities and demographic variables.

Also, given that mental health is political and cannot be approached or understood in a vacuum from the broader political climate, future research studies could examine the impact of managed care legislation and the broader political discourse about cultural difference on the counselors' development of disability counseling competence and client's experiences of the counseling services. For instance, given the recent proposed changes in health care reform laws, future studies could examine counselors' development of disability counseling competence while meeting systemic expectations for clients' progress in less frequent or shorter counseling sessions. Future studies could also illuminate the relationship between the public discourse around disabled bodies and counselors' negative attitudes and personal dispositions that inform biases, prejudices, and assumptions about disabled clients' dignity and rights to experience wellness, development, and resiliency.

The participants in this study had varying levels of experience working with clients with disabilities. Some participants expressed having one client with a disability while other participant expressed having a caseload of 112 disabled clients. Even though my analysis did not separate participants into sub-categories, future research could examine the relationship between experience and disability counseling competence. Similarly, participants expressed varying levels of post-graduation training related to disability. Even though my study did not elucidate the differences in the counselors' process of development based on amount or nature of post-graduation training, future research could explore the impact of this training in the development of disability counseling competence. Additionally, future research could explore the resistances that counselor trainees or professional counselors experience regarding learning about disability. Lastly, further research efforts are needed to ascertain if disability counseling competence is a distinct construct from multicultural counseling competence.

This study's sample only included clinical mental health counselors. Further research could also examine the particularities of the development of disability counseling competence in counselors graduating from different tracks in CACREP-accredited counseling programs. For instance, future studies could recruit samples from different counseling tracks and compare the counselors' development of disability counseling competence based on the differences in training. Moreover, given the new opportunities resulting from the merge of CACREP and CORE, future research could examine the development of disability counseling competence of the graduates from the Clinical Rehabilitation track in order to identify the training components that inform their development of disability counseling competence and intentionally integrate them in other specialties. Moreover, given the curricular requirements that cover social and political aspects of disability in this new track, further research could attend to counselors' evolving ***recognition of disability as a cultural group*** and compare it to counselors graduating from other tracks in order to identify the main learning factors that facilitate this development. Additionally, this study's sample focused on clinical mental health counselors working on different practice settings. Further research could examine the development of disability counseling competence across setting by systematically including the representation of places of employment in the recruitment of participants.

Additionally, the historical exclusion of people with disability's involvement in scientific research and other cultural dimensions of everyday life has perpetuated further conditions of segregation, powerlessness, isolation, and misrepresentation of their lives and needs (Charlton, 1998; Olkin, 2003). This emergent grounded theory sought to only represent the processes occurring on the counselors who provide services and did not attempt to theorize about people with disabilities' lives. Thus, the construction of this theory is inherently partial in that it did not

include the personal accounts of clients with disabilities who use these counseling services to navigate mental distress while facing the effects of living in a disabling society (Reeve, 2000). The lack of disability-centric perspectives of disability counseling competence is one of the major limitations of this study. The generation and documentation of insider perspectives of disability counseling competence could further inform the counseling profession. Future research studies could focus on attending to disabled clients and their families, as well as disabled counselors' constructions of disability counseling competence.

Another research study could examine the psychological and professional impact of occupational stress in mental health counselors' development of disability counseling competence represented by the ***productivity demands in mental health systems***. For instance, research could focus on illuminating the lived experiences of professional counselors in the mental health system that inform burn out rates as well as ethical misconduct. Also, future grounded theory studies could illuminate the development of emotional awareness and self-care practices enacted by professional counselors working with clients with disabilities.

Moreover, further research could focus on correlational measures between the development of disability counseling competence and counselor professional identity. The illumination of this relationship could guide the profession's efforts around strengthening and deepening counselor professional identity. Moreover, studies that quantitatively examine the relationship between disability counseling competence and professional identity between mental health counselors and rehabilitation counselors could further inform and support ACA's 20/20 strategic plan for an unified counseling professional identity (Kaplan & Gladding, 2010).

A final research recommendation would involve a study that examines the impact of using this emergent grounded theory within clinical supervision to support licensed professional

counselors' development of disability counseling competence. Specifically, further research could assess the impact of using this emergent grounded theory in clinical supervision as an intervening variable in a pre and post experimental design. The experimental group would be exposed to this emergent theory's narrative and diagram. The control group would not receive this information. Pre and post measures of the development of disability counseling competence in both groups could illuminate the impact of this intervention in counselors' development of disability counseling competence, specifically regarding their ***understanding and use of privilege***, ***recognition of disability as a cultural group***, and **The Therapeutic Work** with clients with disabilities. This research endeavor could afford generalizable results that could be applied to multiple settings of clinical practice. Moreover, substantiating these results with qualitative designs aimed to capture and represent counselors' lived experiences receiving this information and guiding their development of disability counseling competence with an existing model could further account for the value of this experimental intervention.

Conclusion

This study offers a detailed description, analysis, and graphic illustration of licensed professional counselors' development of disability counseling competence. Twenty licensed professional counselors who graduated from CACREP-accredited counseling programs, and who currently work with clients with disabilities engaged in this research process and described their experiences of development of disability counseling competence. The evolution from earlier stages of multicultural development defined by negative attitudes and emotional reactions to the achievement of disability counseling competence and sense of purpose was thoroughly examined through a consistent and reciprocal research engagement. Specifically, all twenty participants engaged in two rounds of interviews and two interpretive dialogue interviews on order to share,

amplify, refine, and confirm their descriptions. Hence, the emergent grounded theory co-constructed in this current study provides the counseling profession with a rich depiction and greater understanding of licensed professional counselors' development of disability counseling competence.

Many scholars have emphasized the need to increase counselors' multicultural competence in order to enact meaningful professional commitments for equity, social justice, and human dignity (Arredondo & Toporek, 2004; Ratts et al., 2016; Ratts & Pedersen, 2014). Moreover, scholars have also called for attention to disability issues in the training of mental health professionals (i.e., Olkin & Pledger, 2003; Pledger, 2003; Smart & Smart, 2006; Reeve, 2000, 2006; Swain et al., 2006). The participants in this study reflected on their multicultural experiences with clients with disabilities and identified the main factors in their process of development of competence to work with these clients. Even though this process of development is highly complex, intertwined, and can be illustrated in multiple ways, this research study provided an in-depth examination of the categories, properties, and dimensions to meaningfully illuminate the essential aspects of licensed professional counselors' development of disability counseling competence.

Appendix A: State Licensure Requirements

Table 1

State Licensure Requirements

State	Credential Title(s)	Education requirements	Experience required	Exam required
Connecticut CT Department of Public Health Professional Counselor Licensure 410 Capitol Avenue, MS #12APP P.O. Box 340308 Hartford, CT 06134-0308 860/509-7603 860/509-8457 (fax) oplc.dph@ct.gov http://www.ct.gov/dph/	Licensed Professional Counselor (LPC)	60 credits Master's degree in counseling or related field	1 year/3,000 hours of post-master's supervised experience.	NCE or NCMHCE
Delaware DE Board of Mental Health and Chemical Dependency Professionals Cannon Building 861 Silver Lake Boulevard, Suite 203 Dover, DE 19904-2467 302/744-4500 302/739-2711 (fax) http://dpr.delaware.gov	Licensed Professional Counselor of Mental Health (LPCMH) Licensed Associate Counselor of Mental Health (LACMH)	Master's degree or higher, including a minimum of 48 semester hours. Must also be certified by NBCC as a National Certified Counselor (NCC), or certified by another national mental health specialty certifying organization approved by the board.	2 years/3,200 hours of full-time clinical professional counseling experience to be completed within a 4 year period. 1,600 hours must be professional direct supervision acceptable to the board (100 hours must be face-to-face supervision).	NCE or NCMHCE
District of Columbia DC Board of Professional Counseling 717 14th Street, NW, Suite 600 Washington, DC 20005 202/724-4900	Licensed Professional Counselor (LPC)	60 credits Master's degree in counseling or related field	2 years/3,500 hours of post-masters supervised professional counseling experience	NCE, NCMHCE, or CRCE

877/672-2174
202/727-8471 (fax)
http://hpla.doh.dc.gov/hpla

Maine ME Board of Counseling Professionals Licensure #35 State House Station Augusta, ME 04333 207/624-8674 888/577-6690 TTY 207/624-8637 (fax) www.maine.gov/pfr/olr	Licensed Clinical Professional Counselor (LCPC) Licensed Professional Counselor (LPC)	LCPC: Master's degree or higher from a regionally accredited institution that consists of 60 semester hours and is CACREP accredited, or consists of coursework in 10 core areas, 3 additional areas, and a practicum and internship of 900 clock hours. LPC: Master's degree or higher from a regionally accredited institution that consists of 48 semester hours and is CACREP or CORE accredited, or consists of coursework in 10 core areas and a practicum and internship of 600 clock hours.	LCPC 2 years/3,000 hours of post-master's supervised clinical counseling experience. LPC 2 years/2,000 hours of post-master's supervised counseling experience.	NCE or NCMHCE
Massachusetts MA Board of Registration of Allied Mental Health and Human Services Professionals 239 Causeway Street, Suite 500 Boston, MA 02114 617/727-3080 617/727-2197 (fax) www.mass.gov/dpl/boards/m	Licensed Mental Health Counselor (LMHC)	Minimum of 60 graduate semester hours in counseling or a related field from a regionally accredited institution of higher education. or	2 years/3,360 hours of full-time post-master's supervised clinical experience in mental health counseling after obtaining 60 graduate semester hours.	NCMHCE

		Hold a current Certified Clinical Mental Health Counselor (CCMHC) credential issued by NBCC.		
New Hampshire NH Board of Mental Health Practice 121 South Fruit St. Concord, NH 03301 603/271-6762 603/271-3950 (fax) bdmhp@ng.gov http://www.nh.gov/mhpb/licenseees.html	Licensed Clinical Mental Health Counselor (LCMHC)	Master's degree or higher in counseling or psychology from a regionally accredited college/university, which consists of a minimum of 2 academic years of full-time graduate study related to mental health counseling, 60 graduate semester hours, and coursework in 9 content areas (program must meet the board's approval).	2 years/3,000 hours of paid post-master's supervised clinical work experience in a mental health setting, to be completed in no more than 5 years.	NCMHCE and an essay exam provided by the board.
New Jersey NJ Board of Marriage & Family Therapy Examiners Professional Counselor Examiners Committee P.O. Box 45007 Newark, NJ 07101 973/504-6582 973/648-3536 (fax) http://www.njconsumeraffairs.gov/mft/Pages/default.aspx	Licensed Professional Counselor (LPC) Licensed Mental Health Counselor (LMHC)	Minimum of 60 graduate semester hours which includes a master's degree in counseling from a regionally accredited institution of higher education	3 years/4,500 hours of full-time supervised counseling experience in a professional counseling setting, 1 year of which may be obtained prior to the granting of the master's degree.	NCE
New York State Board for Mental Health Practitioners Office of the	Licensed Mental Health Counselor	Master's degree or higher in counseling that includes 60	3,000 hours of post-master's supervised experience providing mental health	NCMHCE

Professions State Education Building, 2nd Floor 89 Washington Avenue Albany, NY 12234-1000 518/474-3817, x450 518/486-2981 (fax) mhpbd@mail.nysed.gov http://www.op.nysed.gov/prof/mhp and www.op.nysed.gov/mhclic.htm	(LMHC)	semester hours and completion of specific coursework.	counseling in a setting acceptable to the department.	
North Carolina NC Board of Licensed Professional Counselors P.O. Box 77819 Greensboro, NC 27417 336/217-6007 336/217-9450 Board Administrator Katrina Brent CONTACT: LPCinfo@ncblpc.org WEBSITE: www.ncblpc.org	Licensed Professional Counselor (LPC)	Master's degree in counseling or related field from an institution of higher education that is either regionally accredited or accredited by an organization both recognized by the Council for Higher Education Accreditation and accredited by CACREP.	3,000 hours of supervised professional practice; 2,000 hours must be direct counseling. 100 hours of clinical supervision required.	NCE, NCMHCE, or CRCE and NC jurisprudence exam
Pennsylvania PA State Board of Social Workers, Marriage & Family Therapists, and Professional Counselors P.O. Box 2649 Harrisburg, PA 17105-2649 717/783-1389 717/787-7769 (fax) st-socialwork@state.pa.us www.dos.state.pa.us/social	Licensed Professional Counselor (LPC)	60 credits master's degree in professional counseling or in a field closely related to the practice of professional counseling including a 48 semester hour (or 72 quarter hour) master's degree in professional counseling or in a field closely related to the	3 years/3,600 hours of supervised clinical experience after completing 48 graduate level credits (or 72 quarter hours).	NCE, CRCE or other forms of tests.

		practice of professional counseling. or Doctoral degree in counseling or in a field closely related to the practice of professional counseling.		
Puerto Rico PR Office of Regulation and Certification of Health Professionals Board of Examiners of Professional Counselors P.O. Box 10200 San Juan, PR 00908 787/723-0102 www.salud.gov.pr	Licensed Professional Counselor (LPC) Professional Counselor with Provisional License (PCPL)	Master's degree or higher in counseling from an institution accredited by the Council of Higher Education of Puerto Rico.	Completion of a minimum of 500 hours post-master's practice supervised by a Certified Mentor. Upon approval of the exam required, the board shall issue a provisional license.	NCE
Rhode Island RI Board of Mental Health Counselors and Marriage & Family Therapists 3 Capitol Hill, Room 104 Providence, RI 02908 401/222-2828 401/222-1272 (fax) http://health.ri.gov/licensing/healthcare/#mental	Licensed Clinical Mental Health Counselor (LCMHC)	Master's degree or higher specializing in counseling/ therapy from an university accredited by the New England Association of Schools & Colleges or an equivalent regional accrediting agency. or Master's degree, certificate in advanced graduate studies, or doctoral degree in mental health counseling or allied field from a recognized educational	2 years/2,000 hours of postmaster's direct client contact offering clinical or counseling or therapy services with emphasis in mental health counseling.	NCMHCE

institution.

Vermont	Licensed	Master's degree	2 years/3,000 hours	NCE and
	Clinical	or higher in	of postmaster's	NCMHCE
VT Board of Allied Mental	Mental	counseling from	experience in	
Health Practitioners	Health	an accredited	clinical mental	
89 Main St. 3rd floor	Counselor	institution, with	health counseling,	
Montpelier, VT 05620-3402	(LCMHC)	a minimum of 60	including 2,000	
800/828-1505		semester hours	hours of direct client	
802/828-2465 (fax)		and 1,000 hours	contact.	
Diane.lafaille@sec.state.vt.us		of a supervised		
http://vtprofessionals.org		practicum,		
		internship, or		
		field experience		
		in a clinical		
		mental health		
		setting.		

Note. Adapted from "Licensure Requirements for Professional Counselors," Copyright 2016 by the American Counseling Association.

Appendix B: Syracuse University IRB Approval Letter

SYRACUSE UNIVERSITY

INSTITUTIONAL REVIEW BOARD
MEMORANDUM

TO: Nicole Hill
DATE: November 28, 2016
SUBJECT: **Expedited Protocol Review - Approval of Human Participants**
IRB #: 16-331
TITLE: *The Development of Disability Competence: A Qualitative Investigation of Licensed Professional Counselors' Perspectives*

The above referenced protocol was reviewed by the Syracuse University Institutional Review Board for the Protection of Human Subjects (IRB) and has been given **expedited approval.** The protocol has been determined to be of no more than minimal risk and has been evaluated for the following:

1. the rights and welfare of the individual(s) under investigation;
2. appropriate methods to secure informed consent; and
3. risks and potential benefits of the investigation.

The approval period is **November 28, 2016** through **November 27, 2017**. A continuing review of this protocol must be conducted before the end of this approval period. Although you will receive a request for a continuing renewal approximately 60 days before that date, it is your responsibility to submit the information in sufficient time to allow for review before the approval period ends.

Enclosed are the IRB approved date stamped consent and/or assent document/s related to this study that expire on <u>November 27, 2017</u>. **The IRB approved date stamped copy must be duplicated and used when enrolling new participants during the approval period** (may not be applicable for electronic consent or research projects conducted solely for data analysis)**.** Federal regulations require that each participant indicate their willingness to participate through the informed consent process and be provided with a copy of the consent form. Regulations also require that you keep a copy of this document for a minimum of three years after your study is closed.

Any changes to the protocol during the approval period cannot be initiated **prior** to IRB review and approval, except when such changes are essential to eliminate apparent immediate harm to the participants. In this instance, changes must be reported to the IRB within five days. Protocol changes must be submitted on an amendment request form available on the IRB web site. Any unanticipated problems involving risks to subjects or others must be reported to the IRB within 10 working days of occurrence.

SYRACUSE UNIVERSITY

Thank you for your cooperation in our shared efforts to assure that the rights and welfare of people participating in research are protected.

Andrew London
IRB Chair

DEPT: Counseling & Human Services, 440 Sims Hall   **STUDENT:** Michele Rivas

Appendix C: Demographic Questionnaire

Please complete the following questions.

Years of practice as licensed professional counselor: _____

Year of graduation from CACREP-accredited counseling master's program: _____

Age: _____

Gender identity: _____

Race: _____

Ethnicity: _____

Sexual orientation: _____

Primary language: _____

Disability: _____

Employment status: Full-time _____   Part-time _____ Other _____

Counseling practice setting: _____

Number of clients with disabilities on current caseload: _____

Please mentioned any post-graduation training/professional development related to disability (if applicable): _____

  Were you a trainer or attendee: _____

Appendix D: Participant Informed Consent Form

1

INFORMED CONSENT

COUNSELING AND HUMAN SERVICES
130 College Place, Suite 440,
Syracuse, NY 13244. Phone: (315) 443-2266

The Development of Disability Competence:
A Qualitative Investigation of Licensed Professional Counselors' Perspectives

My name is Michele Rivas; I am a doctoral candidate at Syracuse University. I am inviting you to participate in my dissertation study. Involvement in the study is voluntary, so you may choose to participate or not. This sheet will explain the study to you, and please feel free to ask questions about the research if you have any. I am happy to explain anything in detail if you wish.

I am interested in learning more about licensed professional counselors' development of disability competence. You will be asked to participate in two interview rounds, each round consisting of a 40-60 minutes interview and a subsequent 15-25 minutes member check interview, both through phone calls or Skype. This will take approximately 120-150 minutes of your time in total. All information will be kept *confidential.* I will assign a number to your responses, and only I, Michele Rivas, will have the key to indicate which number belongs to which participant. In any articles I write or any presentations that I make, I will use a made-up name for you, and I will not reveal details about your personal information or specific details about your place of practice. The places of practice will be described in terms of community agency, school/higher education setting, private practice, government agency, etc.

These interviews will be recorded for transcription and analysis purposes. Only Michele Rivas will have access to the recordings. None of the audios will be used; only the statements from the data will be used for written publication and presentations maintaining confidentiality of your identity (names will be changed.) After a year from the completion of this study, all recording files will be erased.

The benefits of participating in this study will be that your voice as a licensed professional counselor will be heard in regards of your perceptions of disability competence, and through this, you may contribute to the betterment of the counseling training programs and quality of services for people with disabilities. The risk involved in your participation is that some participants could fear retribution from their employment setting because of potentially speaking critically of their competence to work with clients with disabilities. However, information in this study will be handled confidentially, and efforts will be taken to not provide details or quotes that could allow a participant or employment setting to be identified. If you do not want to take part, you have the right to refuse to take part, without penalty. If you decide to take part and later no longer wish to continue, you have the right to withdraw from the study at any time, without penalty.

2

If you have any questions, concerns, complaints about the research, contact my Dissertation Chair, Dr. Nicole R. Hill at (315) 443-2266. If you have any questions about your rights as a research participant, you have questions, concerns, or complaints that you wish to address to someone other than the investigator(s), contact the Syracuse University Institutional Review Board at 315-443-3013.

All of my questions have been answered, I am 18 years of age or older, and I wish to participate in this research study. I have received a copy of this consent form.

____ I agree to be audio recorded.

____ I do not agree to be audio recorded.

_____   _____
Signature of participant   Date

_____
Printed name of participant

_____   _____
Signature of researcher   Date

_____
Printed name of researcher

Appendix E: Demographic Description of the Participants

Table 2
Participant Demographic Table

N		Age	Gender Identity	Sexual Orient.	Race/ Ethic	Language	Disability Status	Year of grad.	Years of Licensed Practice	Practice Setting	# of Clients w/D	Post-graduation Training Related to Disability
1	Allison	28	F	H	C	E	N	2012	3	OP	3	2
2	Brittney	29	F	H	C	E	N	2013	1.5	DP	17	>10
3	Cortina	36	F	H	L	E&S	N	2005	8	PP	4	0
4	DDD	31	F	H	C	E	Y	2014	1	OP	30	1
5	Eliza	27	F	H	C	E	N	2014	1	OP	52	1
6	Faith	39	F	H	C	E	N	2002	10	OP	11	0
7	Gloria	59	F	H	C	E	N	2009	5	PP	3	1
8	Henry	38	M	H	C	E	Y	2006	8	OP	38	>10
9	Iris	44	F	H	C	E	N	1996	9	SB	9	3
10	Jerome	32	M	H	C	E	N	2010	4	PP	3	0
11	Kara	28	F	H	C	E	Y	2013	1	OP	35	1
12	Lynn	36	F	H	C	E	Y	2005	10	OP	1	>10
13	Maria	44	F	H	C	E	Y	2001	10	OP	19	>10
14	Natalie	33	Q	P	C	E	Y	2013	2	HE	30	0
15	Otilia	37	F	H	--	E	N	2014	9	SB	1	0
16	Peter	46	M	G	C	E	Y	2010	4	HE	112	>10
17	Queen	37	F	H	C	E	Y	2008	6	HE	12	>10
18	Reece	30	F	--	C	E	N	2011	1.5	OP	8	0
19	Sarah	39	F	H	C	E&S	N	2013	1	PP	4	0
20	Tela	40	F	O	C	E	N	2010	2	PP	4	1
21	Unice	42	F	H	H	E	--	2012	2.5	PP	1	1

Notes. F= Female, M=Male, Q=Queer, H=Heterosexual, P=Pansexual, G=Gay, O=Open, C=Caucasian, L=Latina, H=Hispanic, E=English, S=Spanish, Y=Yes, N=No, OP=Outpatient, DP=Day Program, PP=Private Practice, SB=School-based, HE=Higher Education, D=Disability

Appendix F: Questions for First Interview

I am conducting a study about licensed professional counselors' development of competence working with clients with disabilities. As a licensed professional counselor, your experiences are valuable to understand the development of competence working with clients with disabilities and further inform counselor training and counselor identity advocacy. I appreciate your participation in this interview. Your participation is completely voluntary and your consent may be withdrawn at any time

Experiences working with disability

1. How would you describe/can you talk a bit about your experiences counseling people with disabilities?
   - What kinds of disability have you encountered in your practice?
   - What have you learned about this population as a licensed counselor?
2. What have been the facilitating/meaningful factors for you personally and professionally when developing your competencies with counseling clients with disabilities?
   - Can you recall a remarkable or critical experience that reflects this?
3. What have been the challenges/most difficult aspects you have encountered personally and professionally when developing your competencies with counseling clients with disabilities?
   - Can you recall a remarkable or critical experience that reflects this?
4. What has been the process of handling these facilitating factors/challenges as a licensed professional counselor?
   - What factors have been involved? Supports/resources involved?

Self-assessment and process of development of disability competence

5. How would you describe your current level of competence working with clients with disabilities?
   - How does this competence working with clients with disabilities look like in general? specifically for you?
   - How is this competence situated in terms of awareness, knowledge, and skills?
   - What are the indicators you take into account when defining your level of disability competence?
6. If this is the case, how has your competence working with clients with disabilities evolved over time? In what ways?
   - What has facilitated/hindered this change?
7. How is your competence working with clients with disabilities influenced by the interaction of other cultural identities? In the person of the client? in the counselor?

Multicultural competence vs. disability competence

8. How do you compare the competence working with clients with disabilities with multicultural competence? Similarities? differences?

Any other question/comment?

Appendix G: Interpretive Dialogue 1

Twenty Licensed Professional Counselors (LPC) participated in a qualitative interview that examined their process of working with clients with disabilities and the emerging developing competence to work with clients with disabilities. This document summarizes the emerging themes and subcategories of the preliminary analysis after the first round of interviews. This analysis has been organized in five emerging themes:

The Therapeutic Work	"It takes a Village"	Evolving Compromises	Competence	Systemic Dimensions

The next step is to engage in an interpretive dialogue to co-examine the emerging analysis. Please take a moment to review each of the five themes and consider how well they reflect your experience. Would your interpretation of the phenomenon (the development of competence to work with clients with disabilities) change if these themes were not included or changed? What in the analysis resonates the most with you? What is missing from the analysis from your perspective? What are the dynamics and processes that come into play when developing competence to work with clients with disabilities?

Theme: The Therapeutic Work

The Therapeutic Work with clients with disabilities was defined by most of the participants as "intriguing" and "rewarding," and as an emerging area of development in their role as LPCs. Within this theme, three subthemes were preliminary identified: *Disability as* Identity, *Counseling Relationship*, and *Tailoring the Approach.*

Most of the participants expressed confusion about the classifications of disability and framed it as an identity that directly refers to medical conditions that impact the daily functioning of clients, and that also has elusive boundaries so to include pervasive mental illness, chronic illness, and substance abuse. Many participants situated *Disability as Identity* that goes beyond the medical definitions of functioning to include persistent mental illness and substance abuse. In general, participants have encountered clients with physical (wheelchair users, persons missing limbs, persons with health conditions such as cancer, brain tumors, lupus, traumatic brain injuries), intellectual (intellectual disability, learning disabilities) developmental (Autism, cerebral palsy, spina bifida), and sensory disabilities (deaf, blind) in their professional practice. Some participants utilized a dimension of government benefits to frame their understanding of who is considered disabled. Additionally, participants identified ability to walk, learn, see, and hear as a spectrum that overlaps with mental health distress depending on the client's life circumstances.

Participants unanimously emphasized the need of the *Counseling Relationship* as a foundational aspect of the work with clients with disabilities. Participants insisted on the importance for a client-centered approach when working with this population. This emphasis was manifested in different directions. First, participants mentioned the importance of genuine and compassionate care and of meeting the client where they are at. Second, participants highlighted the importance of connecting with the client through the counseling relationship for them to feel listened and empowered.

Once the counselor has gained understanding about the client's disability through the engagement in the counseling relationship, participants insisted in that meeting the client where they are at requires them to *Tailor the Approach* by clarifying information, checking in continuously, adjusting language, and integrating accommodations based on the client's disability and needs.

> P18 asserted, "say I'm pretty knowledgeable in working with individuals with different disabilities, especially when it prevents them from doing certain things because again, I'll just try to meet them where they're at, see what is the disability, what is it preventing them from doing, link them to resources"
>
> P1 mentioned, "I do have experience working with individuals who claim they have a psychological disability. Or their substance use has impacted them to the point where they cannot function in society. Or they struggle functioning in society due to their substance use [...] But again, I think of disability as developmental disability. I really do, I really do. I really do think of it as cognitive disability and physical disability. I don't think it is the mental health, for which is challenging because it is, but it isn't at the same time. I don't know."
>
> P11 stated, "Definitely, the relationship. I think the relationship is probably the most important. Then again, too, not just always going to back to the same types of interventions, really trying to make the interventions work for the client, and being person-centered. I don't know, it all sounds so textbook, but I feel like it's also true."
>
> P10 commented, "It's just making sure that you stay mindful that there's an extra step. I would say that's pretty common with the folks I work with autism too, is being mindful that the language you use, they may not understand it, or they may not get a social cue, or they may not get a body language, so being mindful of folk's disability in the sense that the role that it plays in the greater sense of how you're counseling them."
>
> P21 stated: I try to get things from the internet that are already translated, you know there is a lot of information on the internet but again, the way it tis displayed it s away that my client might not take advantage of so I will take it from the internet but again I have to modify it so I'll draw pictures, if they are able, I'll do physical activities that kind of send the message you know, using examples form their every day life, I will try to help them gain the understanding that I am looking for in a way that they can relate to"

In the same way these three sub-themes emerged, the participants described the process of realizing the nature of the work with this population: from understanding the disabling condition, fostering and cultivating the counseling relationship, and tailoring the approach according to the goals and the condition of the client. Furthermore, while commenting on this process, the participants mentioned the resources used in doing this work. The next theme "It takes a village" describes the multiple components and resources involved in this work for the participants.

Theme: "It takes a village"

All participants recognized that the counseling work cannot be done in isolation. The participants highlighted the importance of using community and interchange with the extended network of providers to increase the effectiveness of the counseling work. Within this theme, three subthemes (*Collaborative Relationships*, *Learning Communities*, and *Clients/Families Narratives*) and two resulting dimensions (*Circle of Trust,* and *Expertise*) were identified. Participants described this process as continual and persistently ongoing.

Resulting from Never Ending Process
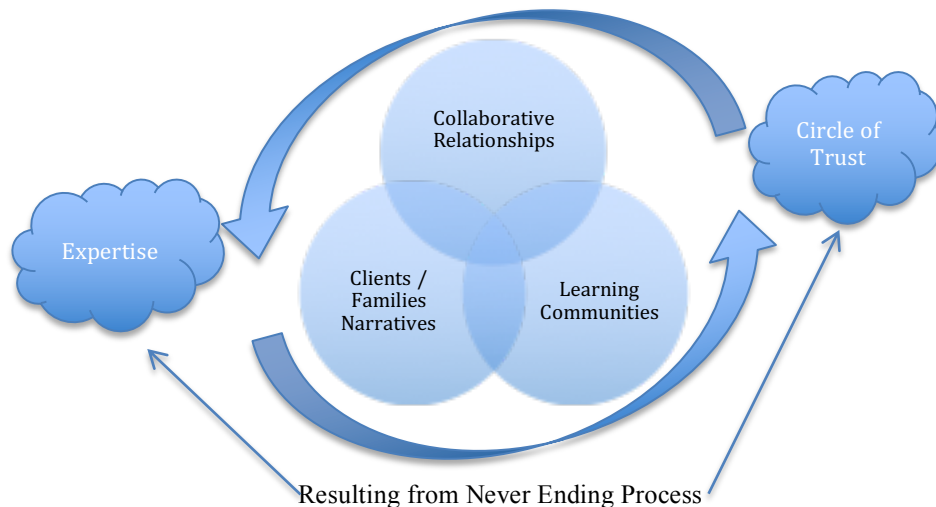
Participants unanimously expressed the importance of the interactions with supervisor, peers, and other professionals (social workers, case workers, Medicaid Service Coordinators, and psychiatrists) through _Collaborative Relationships_. In terms of supervision, the participants highlighted the importance of responsive supervision that not only addresses the needs of the clients but also the development of the counselor. One participant emphasized the need for specialized supervision that would include a supervisor with disability experience. An aspect of the collaboration with others in the professional environment includes other mental health professionals that are in relation with the client or who serve the same population, and therefore represent a source of information and consultation. Also, other participants expressed the importance of having peer consultation and building a support network with peers in the work environment to debrief after sessions and learn from each other, even when some colleagues might have different views of the work.

Participants also mentioned the importance of immersing themselves in Learning Communities (Counseling Associations, Institutional Trainings, and the Internet) to amplify knowledge and get in contact with professional communities that work with similar counseling issues. Participants mentioned the importance of learning from the _Client and their Families' Narratives_ in the attempt to tailor the best approach possible depending on the client's life circumstances and counseling needs.

While describing the components of the community that is needed to do the counseling work with this population, some participants commented on the continuous nature of this immersion in professional, learning, and personal networks and the resulting formation of tight networks of support (_Circle of Trust_). Participants also reported the eventual development of a perceived _Expertise_ in issues consulted and populations served.

> P5 commented, "Supervision. Supervision 100 percent. Supervision with my supervisor, consultation with many different staff, other supervisors, clinicians. Again, collaboration with psychiatry."
> P2 described, "I found that having a really supportive group of co-workers that I became friends with was really helpful. You know, it was kind of like an outlet of people who knew exactly how you felt at the end of the week, that have the same struggles going on. And it was just really easy to let go and, like, kind of do supervision amongst ourselves, I guess you could say, because when I was working in [name of the program], it was...supervisors weren't readily available and they had their own work to do, so supervision among peers was always kind of the best way bounce ideas off of each other and deal with difficult clients."

P19 described this as "I would have to say, by far, peer consultation and clinical supervision has been the best. Although, getting an understanding from a psychiatrist point of view on how certain disabilities will impact - and I, in particular, have my people to go to when I need to [...] so I have clinical social workers to LPCs to psychologists, and even psychiatrists within my circle of trust."

P13 commented, "Because I think there's always more to learn. There's new information all the time, and there's new disorders that are coming out. I'm not an expert, and I never will be. I think I maybe have more expertise than somebody else could, but I never think I'm certainly going to know everything."

P21: "One of my personal frustrations, you know my colleagues, sometimes they don't realize and my colleagues, you know, and I know that they don't mean it with any kind if ill-will, but sometimes they are like oh, you shouldn't be so tired, we do this every single day, and I think to myself, we don't do the same thing every single day, I have two very distinct roles, and you know, I find myself more mentally exhausted because I have to switch my language back and forth and that takes a lot of time"

Aspects of development and awareness present in the participants directly impact the nature of the counseling work with clients with disabilities. These personal and professional dimensions are identified in the next theme, counselors' Evolving Compromises.

Theme: Evolving Compromises

The majority of participants mentioned the evolving compromises to their role as LPCs as well as to the population of clients with disabilities. Within this theme, three sub-themes were identified (*Negative Attitudes*, *Self-Initiation*, and *Sense of Purpose*) as well as two process dimensions (*Reflexivity* and *Time*). Also, participants identified *Experience/Exposure* as the necessary environment for these compromises to evolve through professional practice. Experience/Exposure has been tentatively identified as an additional process variable.
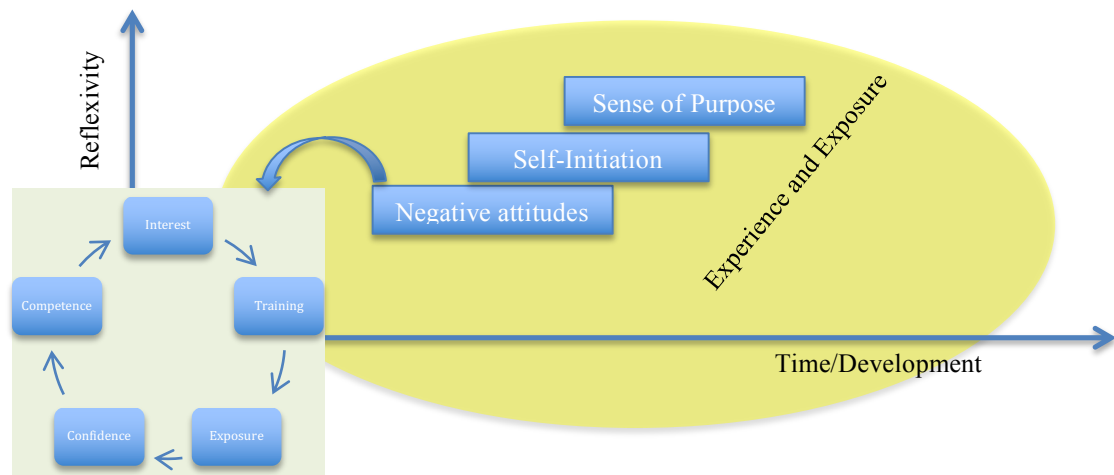
Many participants commented on their initial experiences of avoidance and biases that informed *Negative Attitudes* related to the counseling work with clients with disabilities. From not being interested in the work with this population, participants did not engage or did not actively seek out opportunities for training or exposure to these clients, which decreased their level of confidence and their overall competence to work with clients with disabilities. Negative attitudes were also explained by the participants in terms of biases and the immediate reactions experienced in the work with clients with disabilities.

As the participants moved forward in their evolving compromises to the professional role and the population of clients with disabilities, they reported their desire to get informed and demonstrated *Self-Initiation* in their learning. Furthermore, the participants identified the emerging *Sense of Purpose* as licensed professional counselors working with clients with

disabilities grounded in a two-fold route. First, the participants emphasized the need for personal work to occur. In this personal work, the counselor embraces the struggles, faces assumptions, recognizes privilege, and disrupts the discomfort and avoidance emerging from biases and stereotypes held by the counselor. Second, some participants conveyed their sense of purpose and connection to the population of clients with disabilities once they experience disabling experiences or became disabled themselves.

The sense of purpose was expressed by the participants in terms of the commitment to the professional role and the counseling work, which responds to personal values of meaning and is intrinsically connected to the values of the profession. Within this theme, two process variables were identified. One of these variables was strongly emphasized by some participants and relates to the need for *Reflexivity* and that explains the ability to self-evaluate and self-initiate for more training and consultation when needed. Also, participants identified *Time* as an activator of their development in the work with clients with disabilities given their own personal Development and Maturation process. Another factor impacting the context or the process is *Experience and Exposure* to clientele with disabilities.

> P14 mentioned, "I remember when [the client] came in, my first thought was, ugh, I do not want to work with a person with a disability, especially Autism. That was something that not only did I not feel prepared, I actually didn't want to deal with it. I have zero social issues. I also have zero learning disabilities and zero intellectual deficits. I am literally really, really smart. I was like, I'm never going to be able to connect with these people so I don't ever want to work with them. It sounds horrible but I felt that I couldn't connect, I couldn't understand it so they would be best with someone else. That's what I thought in my head, right. Never really came across it until this person, my first person that had a severe disability in that way and was actually on disability for it, you know social security disability. But because she was transgender and that's my specialty, I was like I've got to stay with her, got to stay with her. Not sending her to somebody else because nobody else is going to be able to take care of the gender piece."

> P3 commented, "I think my personal discomfort with it or with the term and with the condition of disability, not the person, but I think it's hard for me personally especially now that my brother has a disability and I have my own kids, to see people struggling with disability. I think I may find it hard to move beyond feeling pity for them and being able to engage with them in a different way than from pity. So that probably is a challenge as to why I probably avoid the population, because my first personal reaction is just like, I feel sadness, or I feel bad for them, I feel how unfortunate it is. And I guess as a counselor, I don't wanna operate from that perspective with them. So I think I probably avoid it."

> P16 stated, "I think that some of what makes me [competent] is that I, myself, have a disability. As a child I was dyslexic. I am dyslexic. The reason I say "was" is because dyslexia, depending on the person, when you mature into full adulthood, maturation meaning not necessarily emotional but physical, it gets less and less. I'm still dyslexic, but I don't have the kind of problems that I used to when I was a child. So as somebody who had a disability in the early 70s, who went to school when there were no services for individuals with disabilities, there was no such thing as an IEP, and individualized education plan, that didn't start until 1979 when they started to have committees on special education in the public schools. Now at the age that I am of 46 I have a physical disability. I have problems, herniated disks, and things of that nature that cause me physical pain. It's not only on an academic level, whereas when I was a child I struggled with math and I struggled with reading and all of that other stuff, but now as an adult I can also see the angle of the physical disability, and how difficult it must be for somebody who has cerebral palsy who's using a walker or whatever. That's one thing."

> P15 mentioned, "I think what helped me was, like you said, I did an internship. I did some more courses. I got older. I had more experience."

> P6 mentioned, "There's probably some people that are slightly on the spectrum that I've worked with. Because I work primarily with adults I don't see it quite as often. Same thing with the developmental disabilities is it's not quite too severe because in order for them to be able to have the conversation and do actual therapy their developmental disabilities tend to fall on the line of more of a mild and not quite as severe, just for what I've encountered working with myself. I know there's others that are here that are a little bit more severe."

P21: "I am a counselor because I want to help, because I want to alleviate some of the sadness or the maladaptive thinking that people sometimes ends up having for different reasons [...] I know there are so little [Spanish speaking] therapists or counselors out there, individuals they can go to, I know that I have to find a way to keep going [..] I believe in what I do, I believe in the modality of treatment I provide because I have seen it work with individuals with disabilities and I share that with my clients. It is an investment we make together and in completing they experience positive benefits that have a lifelong effect"

The following identified theme presents the preliminary components of competence to work with clients with disabilities based on the participants experiences in the work with this population.

Theme: Competence

The participants described multiple components that are embedded in the emerging concept of competence. Even though there was disagreement around the relationship between multicultural competence (MC) and competence to work with clients with disabilities, all the participants reported a strong relationship between both. Competence to work with clients with disabilities is then defined as part of MC, which requires specialized training. Within this theme, competence is preliminary explained by four subthemes: *Disability as a Cultural Group*, counselor's *Consciousness*, *Interrelated Work*, and *Dimensions of Oppression*. Across this theme, a preliminary process variable was identified: *Becoming vs. Overcoming*.
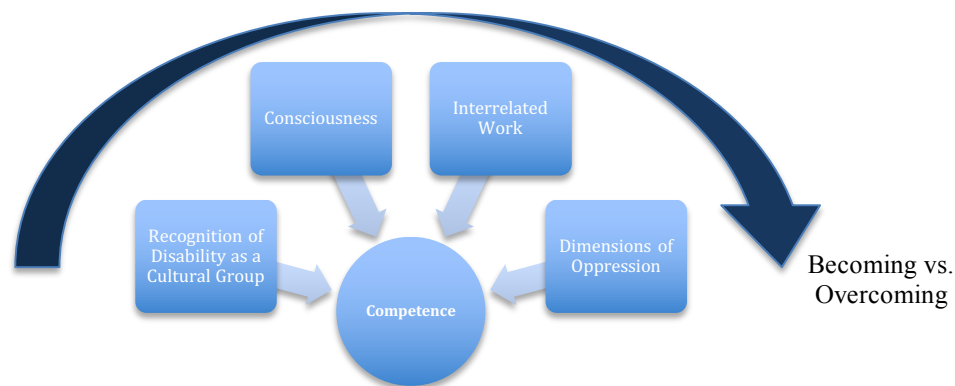
For participants, _Disability is Recognized as a Cultural Group_ given that it is taught as part of multicultural curriculum However, participants stressed this cultural group requires grounding commitments and respect for difference that are specific to the population with disabilities. Moreover, disability represents one aspect of identity that intersects with other multicultural variables in the work with clients.

When mentioning the necessary skills and conditions for the effective work with clients with disabilities and in relation to the needed personal work to achieve sense of purpose (within previous theme), the participants mentioned the importance of _Consciousness_ around this cultural group. Some participants emphasized the need to understand beforehand the nature of the work to foster preparation and commitment as a professional counselor to clients with disabilities as well as any other cultural group.

In congruence with the previous theme of "It takes a village," participants also mentioned the importance for _Interrelated Work_ that goes beyond the counseling room and includes organizations, institutions, and communities of disabled advocates for generating competence. Furthermore, in order to develop competence, several participants highlighted the importance of building coalitions with the disabled community.

Moreover, in order to develop competence, participants commented on the need for counselors to develop expertise and sensitivity around legal and historical _Dimensions of Oppression_ that have defined the history of disenfranchisement of disabled groups, the issues around access and accommodations, as well as the pervasive impact of medicalized narratives of identity. As professional counselors, some participants also stressed the need for self-advocacy to become a dimension of intervention with this population.

Finally, the counseling focus _Becoming vs. Overcoming_ was identified as a process variable within this theme given its precipitating effect for competence that is grounded in human dignity and wellness. Even though some participants described the importance of overcoming issues of adjustment and loss embedded in the disability experience and overcoming them in order to function in more normative ways, as professional counselors, the work around these issues must be grounded in ideas of wellness and resiliency for clients to become their best selves and live full lives.

> P8 commented, "We really do not give working with disabilities enough time. I think that needs more. I think as opposed to trying to infuse working with individuals with disabilities into multicultural training, I think having it's won separate training, specifically about individuals with disabilities. Then it's own separate training about specific individuals with disabilities, like part individuals that may be Hispanic or individuals of eastern backgrounds or individuals of African American descent. If we could actually have specific trainings in regards to each I think that would be great. Because I think, I just don't think that there's enough training."

> P12 stated, "I definitely think that they are related. I think disability and in particular the culture of disability, and even more specific the culture of various disabilities, falls under the umbrella of culture, but I think that the things that fall under the umbrella of culture, it's getting a little crowded under there."

> P9 highlighted, "I have a good relationship with people in the school where I work, 10 years, but none or less sometimes we didn't agree. That would include the teacher, that would include the school psychologist, social workers, school administration. Sometimes there's a lot of people on the other side that are viewing it differently. Not necessarily incorrectly, but they're viewing the child from an educational standpoint, and I'm not. I'm taking that into consideration, of course. Listening to the school psychologist and how she views kids and tests, and the results that come, or the information that comes from that assessment, that's such fantastic information."

> P4 stated, "We have a lot of people telling them things and helping them where they may or may not need the help or understand the help. I try to think, as well, what have they experienced on an institutional level because of their disability, what do they experience from society, how does that impact the way that they are perceiving our time together, and what can I do to make sure that I am taking that into account as I inform myself of my next decision or intervention."

> P17 stated, "I found [and elective taken in graduate program] to be a really helpful base to understand, at times, the loss, the grief process that can sometimes be associated with [disability]"

> P21: sometimes when a client is of Hispanic descent who lacks education, for example I have one client right now who cannot read or write , so some of the handouts or information that I want her to review [...] I can't do that with her [because they are in English], so I have to be creative and find other ways that some times take a little bit longer, so it get's done, but it takes a little bit longer [...] sometimes it is not only the cognitive part but their legal status that, there is like no direction, sometimes the agencies, the resources, they are limited on language as well, the information that my clients are being provided is not to a level of their understanding so there is a long, uhm, it's.. I am trying to find the right word [...]I just start to think about the work with my clients and I am just remembering how sometimes they would go to different resources whether it is the schools, for their children, or for their immigration status, and they would be frustrated because they would be provided all this information and they feel overwhelmed, their level of fear is, I cant even speak on it, because their level of fear is you know, unimaginable and to be able to trust me with some of this personal information, for them is very difficult, so it is frustrating for me because sometimes, I am not fully aware of the process you know, that some of these other entities can provide, so sometimes, again, I am involved on so many different levels, not just counseling the individual but sometimes it is helping them understand some of these other aspects that affect our work, that affect the treatment, so sometimes I find myself in a lot of different directions, you know, to assist them, and

> *sometimes that is overwhelming for me [...] sometimes it creates a lot of work and a lot of avenues that I wasn't prepared for."*

Finally, a theme of Systemic Dimensions was identified as emerging throughout the whole narratives of participants.

Theme: Systemic Dimensions

The participants mentioned different systemic issues and dynamics that directly impact the work with clients with disabilities from the perspective of the client and the counselor. Four subthemes were identified within this theme: the *Double Bind*, *Prejudice and Stigma*, the *Silence of Disability* in curriculum and post-graduation training, and the issues around *Productivity in the Mental Health System*.
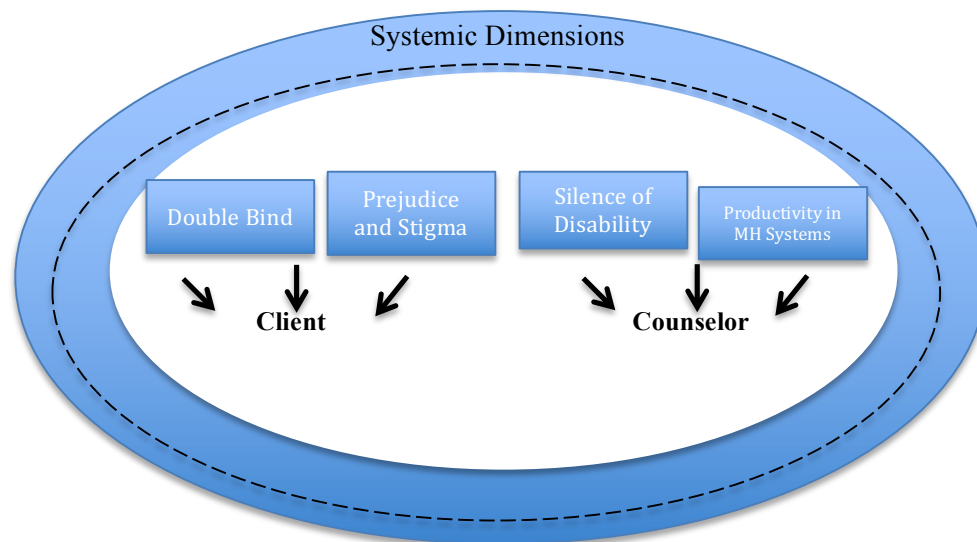
For one part, some participants described the tension between a community of professionals that steps in to meet the needs of clients with disabilities (enacting paternalism and disenfranchisement) but also becomes distant and hard to navigate for clients who are trying to have their needs met by the system. According to the participants, this *Double Bind* dynamic further disenfranchises, disempowers, and removes the initiative of disabled clients.

Another systemic factor impacting the work of LPCs is the *Silencing of Disability* in training standards, required Continual Education requirements, and community representation (Co-facilitators, faculty). This silence of disability awareness in the training not only represents lack of preparation for the counselor doing to do the work but also represents a disservice to the overall community.

Also, participants manifested the realities of expectations and demands in terms of *Productivity in Systems of Mental Health* that compromise counselors' use of time and resources to cover required CEUs, demand the handling of big caseloads, and increasingly requires evidence based outcomes that increase occupational stress for low compensation. One participant expressed that another systemic demand related to productivity was the need to coordinate and perform additional work as a bilingual counselor given the dearth of materials and resources in Spanish. Finally, another systemic aspect encountered in the work with clients with disabilities is the *Prejudice/Stigma* that surrounds this identity, that informs others' reactions to this population, and that increased disengagement of clients from services they don't feel as theirs.

P21 commented: "because my clients have other demands [language] it becomes a little bit more difficult so sometimes I feel like I am doing a lot of extra work, again just to be able to provide them with the treatment that they need in a way that is going to be absorbed in a healthy way for them"

P20 stated, "I think there's also an element where, the two folks I'm thinking of, are highly integrated into the system so there is case managers, there's people that provide transportation, there's a lot of support with them and so I think in some ways, there's then ... Not as much ability to figure things out on their own. There's a lot of support that kind of takes care of a lot of life's challenges that otherwise they might be able to process things a little more. I think there's definitely some ability there that is undermined by a certain level of continual care. [...] I think we also have a system where if someone is on disability, there are actually ... They have to stay sick to get benefits and so I think that's a really bad system. It's hard to tell where wellness is in that and how much wellness is achievable. I think as a therapist, it's really hard to ... See what progress is in a system that actually progress is detrimental to their well-being or to the long-term maybe financial ability of the person."

P7 mentioned, "I can talk about to my training, I feel like in my training, we talked a lot about multicultural issues, several courses on it, but there definitely was not a course on disabilities and working with people with disabilities, and I think that you could apply the same kinds of ideas and theories to it. If you look at Asperger's and say, "Okay they speak a different language. They have a different perspective. They're coming from a different place and you have to know it." That would be an interesting conversation to have with people. I don't see it being done really, unless people seek it out."

Moreover, P12 commented, "When I was doing my master's degree in counseling, we took two courses on working with students with disability. Both were taught by faculty who had disabilities. One class, my instructor was blind and had some physical disabilities. In my other class, there were two instructors, and one of them had a traumatic brain injury and resulting speech difficulties. In those classes, not only were we working in the community with students who had a variety of different special needs, and we were in those classrooms, so we were working with different types of tactile and different kinds of oral stimulation to help with speech and things like that."

Overall Preliminary Theme Analysis:
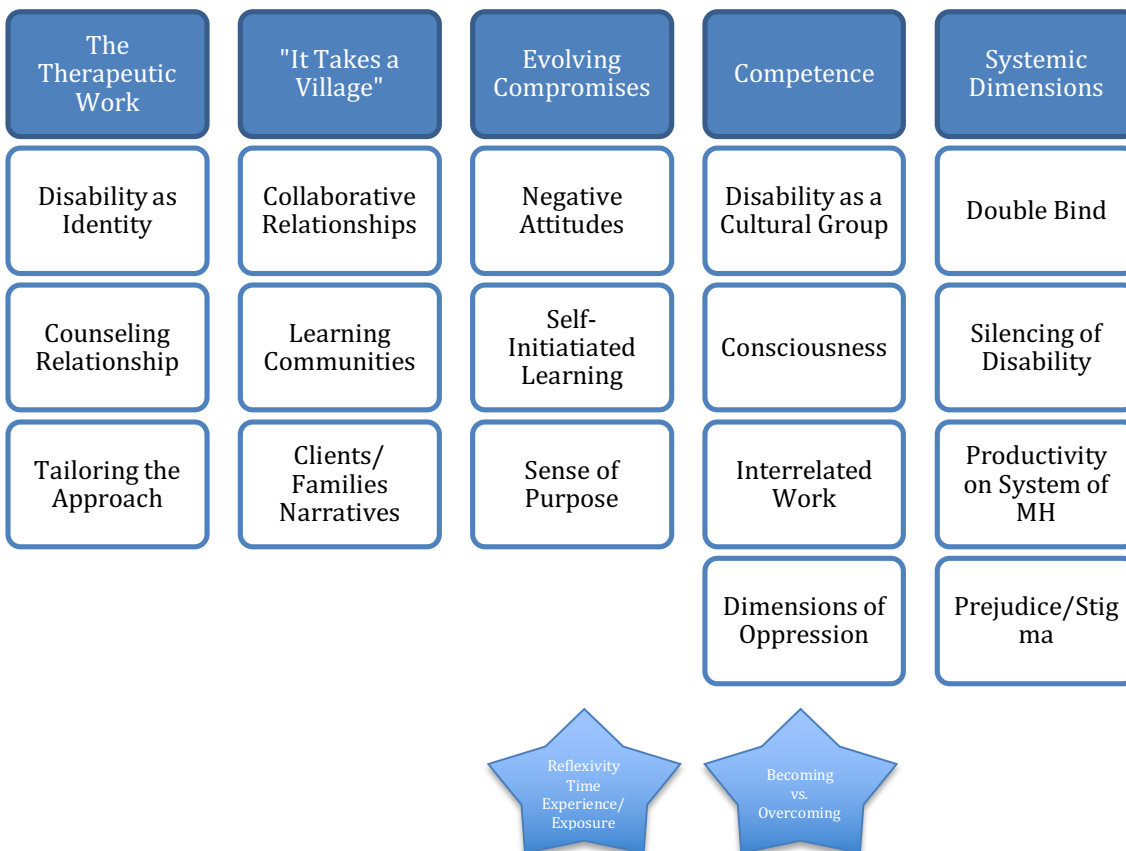
Appendix H: Questions for Second Interview

What is the specific role of ethics in shaping your experiences of development of competence to work with this population?

What aspects of the client's community stimulate or fuel your competence to work with clients with disabilities?

How do you see your power and privilege influencing your ability to work with clients with disabilities? In what ways have these helped/ hindered your process?

In terms of becoming vs. overcoming (progress), how do you privilege one or the other? Which one of these has helped you the most in developing competence to work with clients with disabilities? Can you provide an example?

In what ways do you disrupt the social order that determines the conditions for clients with disabilities in systems of mental health? And how is this used or not as a counseling intervention?

Is there any other factor involved in your development of competence to work with clients with disabilities that we have not discussed so far?

Appendix I: Interpretive Dialogue 2

Emerging Grounded Theory of Counselors' Development of Competence to Work with Clients with Disabilities

Twenty Licensed Professional Counselors have described their process of development of competence to work with clients with disabilities. Figure 1 illustrates the emerging grounded theory after two rounds of analysis.
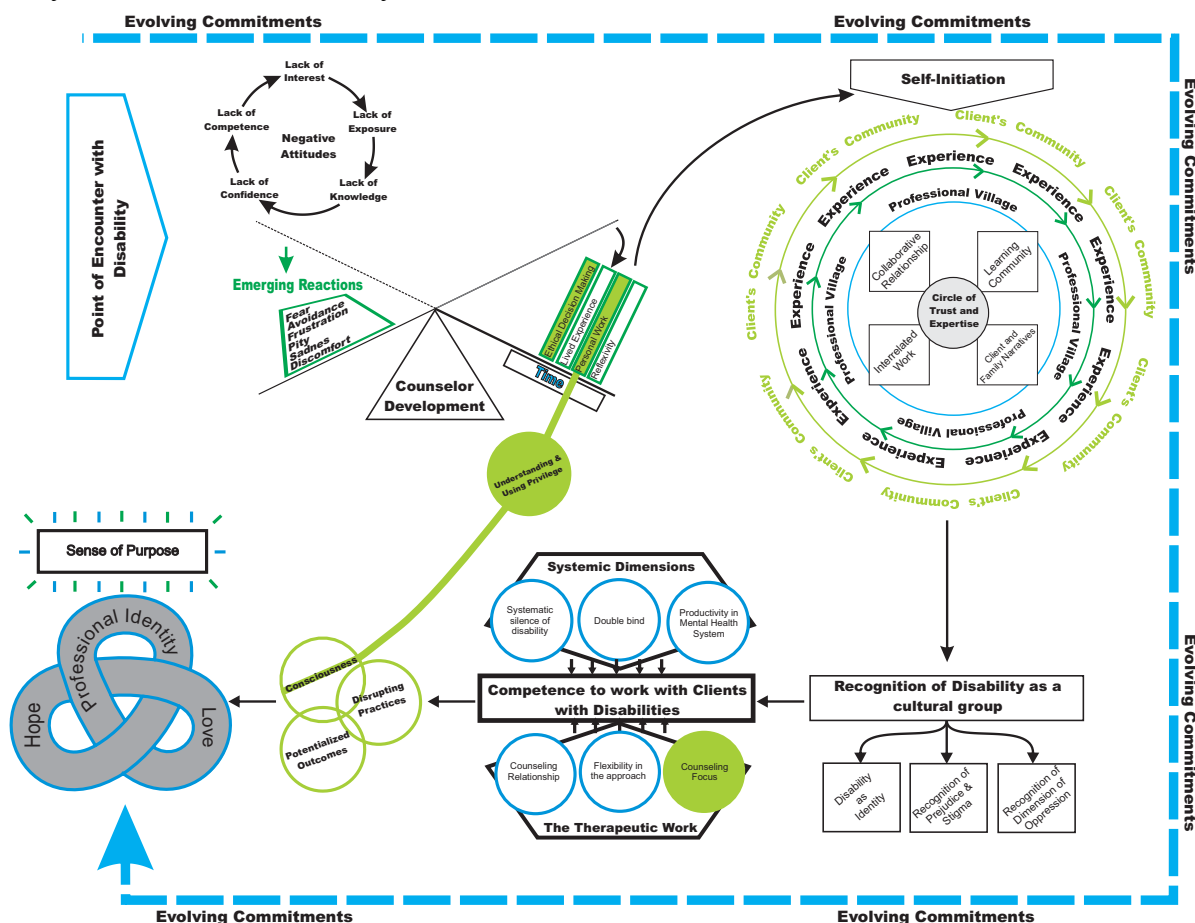
Figure 1. Emerging grounded theory

   The point of encounter with disability was usually related to negative attitudes and significant reactions (fear, pity, sadness, frustration, discomfort, powerlessness, and avoidance) that resulted from an initial lack of interest, exposure, knowledge, confidence, and competence to work with this population. The development of counselors was further mediated by process variables of ethics, lived experience, personal work, and reflexivity. Additional Analytic Factor: From the second round of analysis, ***Ethical Decision Making*** was added to the emerging grounded theory. According to the participants' report, a process of decision-making seems to substantiate the decisions around client care and service continuation. Please read the "Ethical Decision Making" analytical factor for further descriptions.

   Through time, these process variables facilitate the counselor's self-initiation to connect with their professional community to obtain further learning, supervision, and experience. Thus,

once counselors connect with their professional village, they usually benefit from collaborative relationships. These collaborative relationships of counselors with their supervisors, peers, and other mental health professionals facilitate an interrelated work with their learning communities and enhance their development of competence. Throughout this process, counselors also cultivate their self-initiated learning by connecting with their clients and families narratives. These narratives usually lead them to further inquire about the cultural issues pertaining to their client's life circumstances. Additional Analytic Factor: From the second round of analysis, a new layer of community, the ***Client's Community***, was added to the emerging grounded theory. Even though counselors did not actively reach out to this greater community, the participants described some meaningful lessons learned when they have been in contact with the community of people with disabilities. Please read the "Client's Community" analytical factor for further descriptions.

Furthermore, as counselors engage at the broader professional and client's community level, they start recognizing disability as a cultural group. This recognition leads counselor to understand the historical dimensions of disenfranchisement, marginalization, and resistance of this minority group. Here, disability is not only recognized as an unique identity, but counselors seem to become aware of the multilayered dimensions of oppression that have further led to the perpetuation of prejudice and stigma for this minority group in all aspects of the social fabric.

As counselors become more aware of the social realities of their clients and further engage in the professional and client's communities, their competence to work with clients with disabilities starts to emerge. This competence is reflected on counselors' therapeutic work through a variety of factors: the counselors' ability to ground their professional role in the counseling relationship, in the commitment to remain flexible and creative when tailoring the approach to work with these clients, as well as in the intentionality to calibrate the counseling focus in the work with these clients. Additional Analytic Factor: From the second round of analysis, the balance between becoming and overcoming was redefined as the ***Counseling Focus***, in the emerging grounded theory. This change attempts to better capture the nuanced navigation of demands and values in the counseling work with clients with disabilities. Please read the "Counseling Focus" analytical factor for further descriptions.

The competence to work with clients with disabilities is also impacted by systemic dimensions that further inform the counselors' possibilities for the engagement with their professional and client's communities. One of the systemic dimensions impacting the counselors' development of competence is the institutional and systematic silence of disability across curriculum, learning domains, and professional community. Another systemic dimension is the double bind represented by a system that embraces disabled clients to meet their needs, but that becomes inaccessible when clients try to take initiative to change their social circumstances. A final systemic dimension identified is the presence of increased demands for productivity in mental health systems. These demands relate to big caseloads, pressure for measurable outcomes, as well as lack of recognition on the time invested in reaching out the overall community and adapting counseling materials for specific populations, for instance, translating handouts.

Finally, the competence to work with clients with disabilities was reflected in three domains. First, competence was reflected through the counselors' ability for cultivating consciousness by actively implementing in their therapeutic work the recognition of systemic, socio-political, and policy aspects impacting the lives of their clients. Additional Analytic Factor: From the second round of analysis, consciousness was further linked to "personal work" to illustrate the counselors' process of ***Understanding and Using their Privilege*** to stimulate

empathetic understanding and potentialize advocacy. This analytical factor was added to the emerging grounded theory. Please read the "Understanding and Using Privilege" analytical factor for further descriptions.

Second, competence was reflected through potentialized outcomes, which usually referred to the counselors' use of evidence-based practices and the ability to build meaningful relationships with clients that represented alliance, support, and hope. Third, connected to the new analytical factor of Understanding and Using Privilege, counselors use their positionality within the system to further disrupt practices that take away clients' initiative for wellness and personal development. Examples of these disruptions are counselors becoming allies and advocating for clients within the system. The overall process is reflective of counselors' evolving commitments (previously named "Evolving Compromises") that are conducive to personal and professional sense of purpose through the interrelated and endless articulation of hope, love, and professional identity in the work as licensed professional counselors.

Additional Analytic Factors

The second part of this document summarizes emerging analytic factors emerging from the analysis after the second round of interviews. This analysis has been organized into four analytic factors:

Ethical Decision Making	Client's Community	Understanding and Using Privilege	Counseling Focus
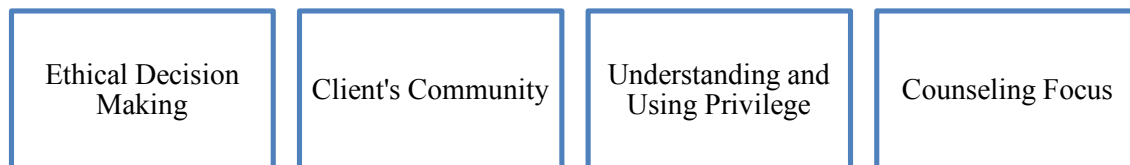
The next and final step is to engage in an interpretive dialogue to co-examine the analysis. Please take a moment to review each of the four analytic factors and consider how well they reflect your experience. Please also consider the comprehensive emerging theory and share your perspective and reflections during the last interpretive dialogue. Would your interpretation of the phenomenon (the development of competence to work with clients with disabilities) change if these analytic factors were not included or changed? What in the analysis resonates the most with you? What is missing from the analysis from your perspective?

Ethical Decision Making
Throughout the analysis, ethical decision making informed the ways in which counselors made service decisions and developed competence to work with clients with disabilities. This dimensionalization of ethical commitments influencing the development of competence fits within the overall analysis as one of the factors that foster counselor's self-initiation. Counselors named issues of confidentiality, boundaries, as well as the ethical commitments for the cultivation of awareness and for seeking out consultation and education when lacking competence. However, the participants' narratives reflected an emerging process of decision-making that seemed to take place when encountering a client with a disability. Therefore, Figure 2 illustrates the emerging process that is informed by counselors' ethical commitments and that delineate their treatment decisions in their work with clients with disabilities.
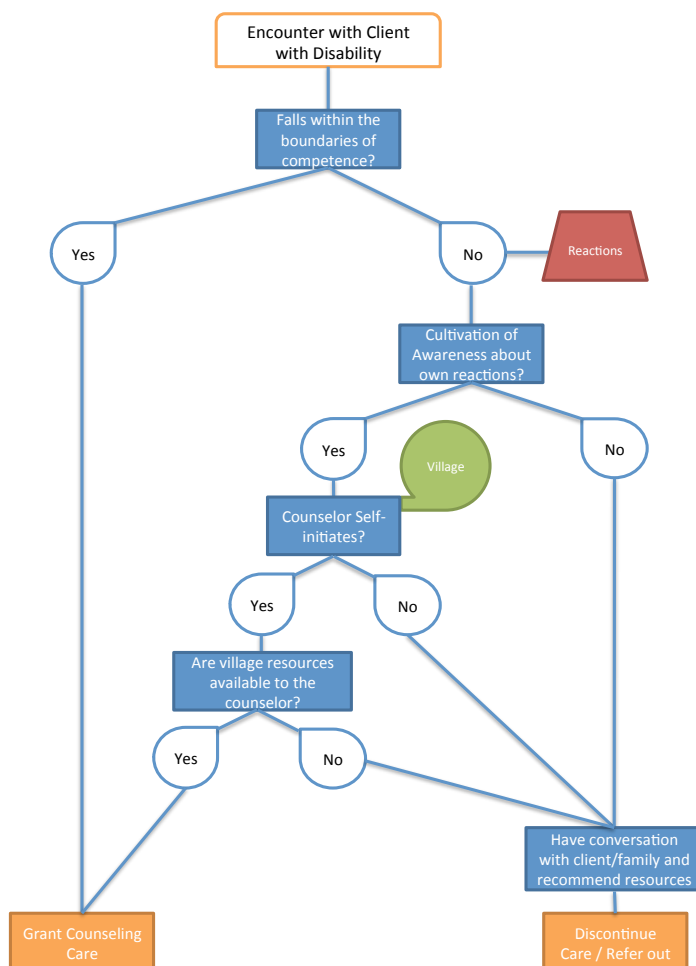
Figure 2. Ethical Decision Making

The decision making process of participants revolved around four main questions. The first question related to the responsibility to operate within the boundaries of competence (*falls within the boundaries of competence?*). When the counselors answered this question positively, it led them to engage in the provision of counseling services for clients with disabilities while grounded in a robust base of knowledge, awareness, and skills. When this question was answered negatively, it not only led the counselors to experience the reactions mentioned before in the emerging analysis (fear, frustration, pity, avoidance), but it also led to the question related to the counselor's willingness to respond to the ethical commitment for the cultivation of awareness about these reactions (*cultivation of awareness about own reactions?*).

When counselors did not honor this commitment for the cultivation of awareness, it led to the discontinuation of care and referring out of disabled clients by first having a conversation about the counselor's lack of competence and the recommendation of services in the client's community. When this question was answered positively, it led the counselors to self-initiate (*counselor self-initiates?*) by engaging in supervision, learning, and peer consultation in their professional community (village) as long as these resources were available (*are village resources available to the counselor?*). When these resources were not available to the counselors, or when

they lacked time or interest for self-initiating, it also led to client referral. However, when these resources were available to counselors, it further led to the engagement of clients in counseling services.

> IRIS - I think its perfectly okay for a professional to say I have never had experience and this makes me uncomfortable ... I mean, that's a journey, that's a professional clinical journey right? So, I mean I jumped in to it pretty early on working with people with disabilities but I think it is all right for someone to realize their own limitations or their own strengths. And to say, you know what, I don't think that I could treat this person. Maybe there is someone else who is better suited for this. Or the willingness to seek ... Their willingness to go with it and to seek supervision. I mean how do you become more comfortable and learn how to work with people with different levels of disabilities? You do it, you do it for a number of years. You seek supervision. You talk with other people involved where appropriate.
>
> KARA - I feel like [I have a] good background. Or I always feel like pretty competent. But certain issues where I've also been blessed really good supervisors so far in this point in my career.
>
> REECE - If we're not you know, helping the client anymore then we're gonna try to see what other resources we can link them to. Like where else can they benefit, where else can they get what they need if we're not helping them anymore. So yeah, and if there's family involved we might talk to them to get their input. Ultimately it's the treatment team's decision.
>
> UNICE - There's an un-comfortability that exists in the session and if we don't have it, it is our duty, in order to provide the proper services to this client, whomever they may be, whatever they may be dealing with, it's our responsibility to find the resources, to connect them, and to maybe later on educate ourselves, so that if there ever is another encounter with a similar situation, we can be better prepared.
>
> JEROME - I have a client come in, I meet them, it just doesn't seem like it's a good fit. Their personality doesn't match with mine, my personality doesn't match with them. As the therapist, I would try to figure out what that is about and I'll try to push through that, but then if that doesn't seem to make things better, I would probably have a conversation about that. I would say, "Listen. I don't know what's working, I don't know what's not, but it feels like something here is not working," and I would have a conversation about it.

As the participants described their ethical decision making process when working with clients with disabilities, they also reflected on the community resources to which to link these clients. The next analytic factor Client's Community describes participants' views of the community pieces that go beyond their professional village and that entail the community organizations of people with disabilities for people with disabilities.

Client's Community
The majority of participants recognized the presence of a disconnection between their professional community and the organization at the client's community level. This dimensionalization of community will be integrated in the overall analysis within the category of village. Some participants expressed their lack of knowledge about and engagement with these communities as well as their hesitance related to the steps to take to approach these communities. Figure 3 illustrates the disconnection between the professional and client's community as reported by the participants, as well as the lessons learned when the counselors have engaged with the client's community.
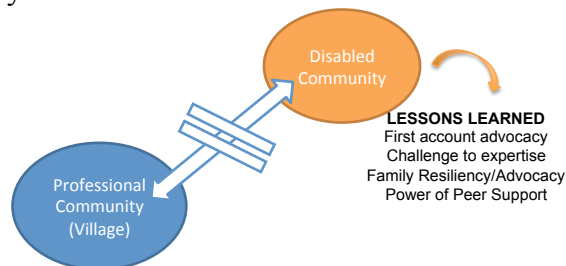

Figure 3. Client's Community

When participants have engaged in the client's community, they learned several lessons that increased their level of competence to work with other clients with disabilities. First, participants mentioned the power of listening and witnessing clients' accounts of their self-advocacy for their needs. Along with these accounts, participants also reflected on their engagement in critical thinking about claims of expertise in treatment decisions. Participants also commented on the stimulation of their competence to work with clients with disabilities, after getting immersed in families' resiliency and advocacy for access and civil rights. Finally, participants reflected on their realization of the power of peer support for disabled clients once getting to know the positive impact of peer support emerging from their own communities.

> QUEEN - So because I had worked at an independent living center, the clinic that I was at, we would have an annual professional development conference, and there was a young man who came in and spoke to us. He was from the western New York region. He was a person with autism, and he had been, actually he might still be in a supportive apartment situation, but he really spoke about the Autism Speaks movement, and how he felt that was really detrimental to him and his peers as they moved into adulthood, and how it was really a single-focused force. It was for parents who were advocating for accommodations for their students, for their children more than it was for having an appreciation and recognition for the diversity of the unique individual. So he really kind of talked a lot about that and his need for more autonomy, and some of the patronization that comes with some of those. So for me, it's another thing that's challenged me to kind of look at who am I even seeing as an expert, and who am I even seeing as a resource and being able to try as these things present themselves, try and be more attuned to some of the competing thoughts about what's really gonna be beneficial for a unique individual because I think at times they come in direct conflict with each other, both of those movements. So I think there's that. Not necessarily that I'm specifically driven to learn more directly from him, but I think for me, just the idea that, yeah there's these valid competing ideas and philosophies about how you do look at this stuff.
>
> CORTINA - I know one example when I worked with the mother and I had seen the daughter and she had a central auditory processing disorder but that's another type of developmental or cognitive disability and from the mom's story of her connection with support groups and self-education on this topic with the psychiatrist, with the doctors, with even the swim coach because the child is in swim, from the mom explaining how she put that village together to help her child, helped me learn. She helped me understand, well swimming is what helps her focus because it gives her physical sensory input and she's on this medication. She expanded my knowledge about community resources. She really helped me learn well if I see another child with this similar disorder, I could provide those ideas like swimming or medication or connect her with that mom to get more research so that's an example that comes to mind.
>
> LYNN - I think that especially ... like clients, any client, no matter what it is that their, you know, presenting concerns are, no matter what their, you know, demographics, should be encouraged to engage in some level of peer support and peer and self-advocacy. And I think that, like, those were some of the places where I had an opportunity to do a lot of learning. So, for example, in [name of city], I worked with a few different clients who had multiple, actual ... Disabilities actually. But, specifically in terms of their peer community, they were engaged in [name of group], which is a peer support community for peers, run by peers, with chronic mental illness. And, one of my clients was like very involved in leadership of that organization, and through her I met ... You know, not like her introducing me but her suggesting that I go to like, you know, these different things. And basically what they are is community workshops put on by peers. And it was such an incredible chance to learn and also to get like a sort of a deeper perspective of how that community was organizing themselves.

As participants reflected on their ethical commitments as well as their further engagement with their clients' communities, they also reflected on their own privilege in the counseling room and as representatives of the mental health system in front of the client. Participants engaged in the descriptions of how realizing their own privilege has served the purpose of enhancing competence to work with clients with disabilities in different dimensions. These dimensions are identified and described in the next section, Understanding and Using Privilege.

Understanding and Using Privilege

The majority of participants mentioned the realization of their able-bodied and able-minded privilege when working with clients with disabilities. This dimensionalization of privilege awareness will be integrated within the overall analysis under the categories of personal work leading to consciousness. The realization of able-bodied and other privileges related to social class, education level, and language spoken, defined for the participants a two-tiered process of use of their privilege: *To remain aware/sensitive*, and *to notice how the system fails the client*. Figure 4 illustrates the dimensions and sub-dimensions of the participants' understanding and use of their privilege.
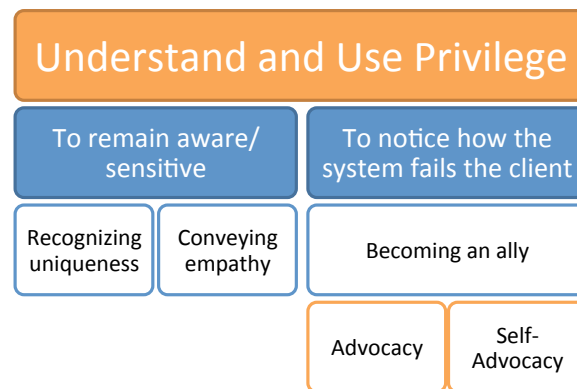

Figure 4. Understanding and Using Privilege

The majority of the participants described their understanding of privilege as informing two continual processes in the work with clients with disabilities. First, counselors described how their acknowledgement and processing of privilege in the counseling room with their clients served the purpose of fostering *awareness to remain sensitive* to the client's narratives. Many participants explained the have never experienced the world as a disabled person, but emphasized the ability to understand the clients' emotional experiences by positioning the clients' as expert and educators of their own experiences. Specifically, the participants named their best intention to understand as much as possible from the clients' descriptions and articulate their resources to help the client resolve their emotional distress and counseling concerns through empathic understanding. Within this process, the participants highlighted the importance of recognizing the uniqueness of the client's lived experiences, as well as the need for the counselors to remain attuned to the clients' difficulties.

Second, participants described how understanding their privilege in the room helped them notice *how the system fails their clients*. Furthermore, by recognizing how their clients have been oppressed by the system, many counselors tended to honor their commitments for social justice by positioning themselves as allies in their clients' lives. Becoming an ally seemed to stimulate the participants' engagement with the client's immediate communities, spark the counselors' initiative for advocacy in their professional communities, as well as increase counselors' investment around clients' self-advocacy skills. Specifically, participants defined advocacy actions as: Initiating conversations, educating their communities around disability issues, and promoting disabled clients' access to services in their own places of employment. Additionally,

participants defined self-advocacy as the clients' encouragement to learn and use skills aimed to represent themselves and their needs in their immediate contexts.

> MARIA - I think to a degree it [recognize privilege] really does help with the empathy part. But, they are right, I don't know what it's like to be in a wheelchair. There are things that are completely different and what I deal with and what someone else deals with is different.
>
> SARAH - I think it goes back to being client-centered and really identifying what the feeling is. Like someone who has addiction. I myself as a professional may not have dealt with any addiction in my own life, but I can identify with loneliness and I can identify with feeling sad and I can identify with anger. I can get back to identifying that. Boiling it down to that underlying feeling. I think the same is true for someone who has a disability understanding the desperation. I can be very honest. I have no problem telling a client, "You know what? I don't know what you're going through." Come from a curiosity type of framework where, "Tell me what that's like for you." Even if I had a disability, my disability might be something different.
>
> TELA - I think acknowledging it [disability issues] with colleagues, especially within the substance abuse field, working in a medical setting. There's a huge amount of cultural stigma, and a big part of that is being willing to have conversations with colleagues or with the nursing staff about language and the power of language and how that has a potential impact on patients we see, how that has a potential impact on not only the patients but the co-workers that might be struggling with these kind of issues, you know? None of us are living in a vacuum. We're all exposed to addictions or mental health. You're just trying to build ... the same kind of thing, really. Being willing to have a conversation within the system and ... you know, in a way that's disruptive.
>
> NATALIE - I think being an ally in the LGBT community, which is the same as for people with disabilities is that understanding where you are and how you're different. You have to understand how you're different, then you have to understand your privilege in this culture. You have to understand their culture and fully, really, look into it like "Yeah. I totally get what life is like for black people. I totally get what life is for a transgender person. I totally get what life is like for someone in a wheelchair." Really get to know people in the community and really get to know what their life is usually like. You can't ever know everyone's life, but you have to educate yourself. Those are all parts of being an ally. I think another part, which is essential is the advocacy. It doesn't necessarily have to be any specific type of advocacy but that your heart is in a place where you would stand up for someone whether it's advocacy that you actually go to a march with someone or go to a meeting for someone with disabilities and help them get what they need from the system or go join a committee that helps make decisions for them to make the school better or the county better, or the state better. All those things are advocacy. Maybe it's something smaller, maybe it's just supporting them in a way where every single time you enter a conversation with someone and someone says something like obviously uneducated or biased about persons with disability or any other oppressed group that you stand up for them. You help educate the rest of the world and that's advocacy too.
>
> ELIZA - And a deep consideration and appreciation for people and their struggles and their obstacles that they face daily.
>
> PETER - I do above and beyond and in addition to because I know it's what's necessary to meet the goal and I can do it.

Whereas a few participants further mentioned the difficulties to engage in advocacy work given their work demands and lack of time, the majority expressed their deep commitments for going "above and beyond" their counselor role when working to meet the client's needs in the system. Furthermore, in planning on what to attend in the sessions with clients with disabilities, participants expanded the idea of demonstrating and measuring progress in the work with these clients. The following and final analytic factor, Counseling Focus, illustrates the participants' descriptions about this topic.

Counseling Focus

The participants described the counseling work with clients with disabilities as a scenario that is mainly guided by the client's lead and that is reflected on the specifics of treatment planning.

The dimensionalization of the counseling focus will be integrated within the overall analysis as part of The Therapeutic Work. Figure 5 illustrates the reciprocal dynamics of the Counseling Focus (informed by *System's Fantasies of Cure* and *Counselors' Intention to Embrace Difference*) as well as the descriptors mentioned by the participants.
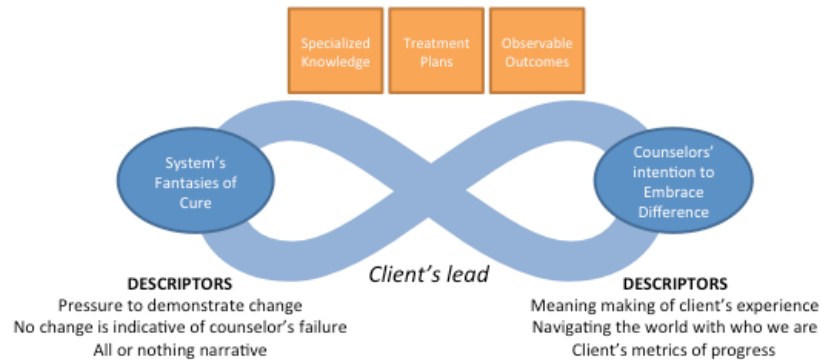

Figure 5. Counseling Focus

Counselors described the counseling focus as abiding to different narratives present in the mental health discourse. Some participants described the counseling work with clients with disabilities responding to *System's Fantasies of Cure* that are situated in the system and which supported the idea of resolving mental health issues and the impact of disabling conditions in order to regain functionality. Here, some participants expressed the pressure to demonstrate observable change in the clients' level of functioning to counter the idea of counselor's failure, as well as the presence of all or nothing narratives when it comes to physical or mental functioning level. On the other hand, participants also highlighted the *Intentionality to Embrace Difference,* which is situated in the counselors' positionality and wellness model. According to the participants, counselors worked towards wellness and embracing difference in order to affirmatively integrate client's different levels of physical and mental ability as a ground for further development, growth, and resiliency through small goals. In here, participants stressed the importance of meaning making, learning to navigate the world with one's own set of abilities, and defining progress according to the client's metrics.

The nature of the counseling focus was not entirely discrete and opposite, but counselors described the reciprocal interactions between the system's fantasies of cure and their intentional work around wellness and embracing difference when enacting their professional role in the mental health system. Thus, the articulation of the counseling focus was grounded in the cultural artifacts of managed care and third party reimbursement, which inform the prominence and authority of specialized knowledge, treatment planning and observable outcomes while aiming for clients' wellness, development, and resiliency. Likewise, participants described their navigation of these reciprocal dynamics depending on the demands of their specific sites of employment as well as client's goals.

> ALLISON - I mean if you are having, if you are suffering from a disability more than likely you are going to have it all of your life. So for me, my goal for everybody is to acknowledge and accept that this is what is happening to me. This is what I am working, what I am going to travel with for the rest of my life and when those moments arise that it hurts me or I get anxious about it or I am angry about it. How do I deal with that? And if you are able to say and identify and use your coping skills and you feel like you don't need to come and practice and talk about it then that is on you. That is when you graduate treatment. But I mean the truth is that is you can't accept, if you are struggling with accepting that I am going to have this,

you will constantly need therapy. You will constantly need to work on it because you haven't acknowledged who you are.

DDD - I think for some of my clients, they really do have to come to terms with their abilities as they are, and once they can explore that aspect of themselves or integrate that aspect of themselves, I guess that would be more of a goal of mine, is to help them integrate their disabilities into their life. Maybe for some people that means being able to rejoin the workforce or overcome the problems that have been imposed by their disabilities. For some people it might be more of just really helping them get to know certain aspects of themselves or their functioning or their life outlook or their abilities, because maybe they haven't been able to explore that or learn that side of themselves. […] In some sense, I can support to overcome problems but I'm looking for a healthy integration of a self, which I think includes quote/unquote "good/bad" aspects of the self. I don't know, maybe it's a little existential or something but I think some of it just has to do with being able to be okay with what is, and so, in some sense, if somebody wants to overcome something, great. I'll see what I can to help them do that, but I think that it gets confusing, because that's not an easily defined concept. […] In general, when it comes to disabilities, I guess the way that I could generalize, something that I keep in mind, is just a healthy integration of self and others.

BRITTNEY - We sit with the client and we ask them, "What are your goals for treatment?" Some of them say, "I want to be independent. I want to live on my own. I want to go back to work. I want to fix family relationships. I want to engage in my community." Usually, we work on two goals, and then we have objectives. The client says, "I want to go back to work." The objective will be, I'll report two actions I have taken per month that will aid me in returning to work, such as building my resume, filling out job applications, going to the library, and using their computer services. We really let the client take the lead with that, and then every time we meet with them, we would discuss their progress towards those goals.

FAITH - Because you can make progress, you can achieve, you can add on from there. But if you set these huge, big goals or so many of them at once, it's overwhelming and it's very difficult for them to really go through and make the progress. As far as documenting it, kind of, in notes way. I think it's really kind of keeping track of everything. And then, simple progress notes of just what they were able to accomplish. These baby steps and all these baby steps might seem really small, for other people, but for them, they're really huge things that could lead up to even more progress.

HENRY - Well, basically what the client wants to work on is what's important to me. Sometimes clients don't necessarily come to see me wanting to overcome their disability, I guess. Like they may be coming to see me for a different reason, so maybe depression, which may be impact of the disability or anxiety or feeling disconnected from the community.

GLORIA - It's not me saying oh this is how you have to be or this is what normal is or this is what's expected of you. It's really saying what is it you want and how can I help you get there?

References

American Counseling Association (2016). *Licensure requirements for professional counselors. A state by state report.* Alexandria, VA: Author.

American Counseling Association (2014). *Code of ethics.* Alexandria, VA: Author.

American Rehabilitation Counseling Association. (n.d.). Understanding Rehabilitation Counseling. Retrieved July 27, 2016, from http://www.arcaweb.org/

Andersen, M. L., & Hill-Collins, P. (2004). Conceptualizing race, class, and gender. In M. L. Andersen & P. H. Collins (Eds.), *Race, class, and gender: An anthology.* (pp. 75-98). Belmont, CA: Wadsworth/Thompson.

Annamma, S. A., Connor, D. J., & Ferri, B. A. (2016). Dis/ability critical race studies (DisCrit). Theorizing at the intersections of race and dis/ability. In D. J. Connor, B. A. Ferri, and S. A. Annamma. (Eds.). *DisCrit. Disability Studies and Critical Race Theory in Education* (p. 9-32). New York, NY: Teachers College Press.

Arredondo, P., & Toporek, R. (2004). Multicultural counseling competencies = Ethical practice. *Journal of Mental Health Counseling, 26*(1), 44-55.

Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., et al. (1996). Operationalization of the multicultural competencies. *Journal of Multicultural Counseling and Development, 24,* 42-78.

Barinaga, E., & Parker, P. S. (2013). Community-engaged scholarship: Creating participative spaces for transformative politics. *Tamara Journal for Critical Organization Inquiry, 11*(4), 5-11.

Bernard, J. & Goodyear, R. (2014). *Fundamentals of clinical supervision.* Upper Saddle River; NJ: Pearson.

Berry, J. L. (2013). *The process of professional school counselor multicultural competency development: A grounded theory* (Doctoral dissertation). Retrieved from ProQuest Dissertation Publishing database. (Accession No. 3570274)

Brandt, E. N., & Pope, A. M. (1997). *Enabling America: Assessing the role of rehabilitation science and engineering*. Washington, DC: National Academy Press.

Brault, M. W. (2012). *Americans With Disabilities: 2010* (Report No. P70-131). Washington, CD: U.C. Census Bureau.

Carpenter-Song, E., Chu, E., Drake, R. E., Ritsema, M., Smith, B., & Alverson, H. (2010). Ethno-cultural variations in the experience and meaning of mental illness and treatment: Implications for access and utilization. *Transcultural Psychiatry, 47*(2), 224-251.

Chang, C. Y., Crethar, H. C., & Ratts, M. J. (2010). Social justice: A national imperative for counselor education and supervision. *Counselor Education & Supervision, 50,* 82-87.

Chang, C. Y., Hays, D. G., & Milliken, T. F. (2009). Addressing social justice issues in supervision: A call for client and professional advocacy. *The Clinical Supervisor, 28*, 20-35.

Clarke, A. E. (2005). *Situational analysis: Grounded theory after the postmodern turn*. Thousand Oaks, CA: Sage Publications.

Corbin, J., & Strauss, A. (2015). *Basics of qualitative research. Techniques and procedures for developing grounded theory.* Thousand Oaks, CA: Sage Publications.

Council for Accreditation of Counseling & Related Educational Programs. (2016). *CACREP accreditation manual: 2016 standards*. Alexandria, VA: Author.

Council for Accreditation of Counseling & Related Educational Programs. (2016). *CACREP and its affiliate CORE announce plans to accept a final round of conversion applications*

prior to the merger implementation date [Press release]. Retrieved from

http://www.cacrep.org/news/cacrep-core-press-release-april-2016/

Creswell, J. A. (2013). *Qualitative inquiry and research design.* Thousand Oaks, CA: Sage.

Davidson, L., & Chan, K. K. S. (2014). Common factors: Evidence-based practice and recovery. *Psychiatric Services, 65*(5), 675-677.

Davis, L. J. (2013). Introduction: Normality, power, and culture. In L. J. Davis (Ed.), *The Disability Studies Reader* (pp. 1-14). New York, NY: Routledge.

Dodson, F. K. (2013). Exploring multicultural competence of school counselors. *The Journal of Counselor Preparation and Supervision, 5*(2), 18-29.

Drum, C., McClain, M. R., Horner-Johnson, W., & Taitano, G. (2011). *Health disparities chart book on disability and racial and ethnic status in the United States*. Durham, NH: Institute of Disability, University of New Hampshire.

Edwards, K. E., & Jones, S. R. (2009). "Putting my man face on": A grounded theory of college men's gender identity development. *Journal of College Student Development, 50*(2), 210-228.

Erevelles, N. (2011). *Disability and difference in global contexts. Enabling a transformative body politic.* New York: Palgrave Macmillan.

Erevelles, N., & Minear, A. (2010). Unspeakable offenses. Untangling race and disability in discourses of intersectionality. *Journal of Literary & Cultural Disability Studies, 4*(2), 127-146.

Eriksen, K., & Kress, V. E. (2008). Gender and diagnosis: Struggles and suggestions for counselors. *Journal of Counseling & Development, 86*, 152-162.

Fassinger, R. E. (2005). Paradigm, praxis, problems, and promise: Grounded theory in counseling psychology research. *Journal of Counseling Psychology, 52*(2), 156-166.

Foster, L. H. (2012). Professional counselor credentialing and program accreditation in the United States: A historical review. *Journal for International Counselor Education, 4,* 42-56.

Gibson, D. M., Dollarhide, C. T., & Moss, J. M. (2010). Professional identity development: A grounded theory of transformational tasks of new counselors. *Counselor Education and Supervision, 50,* 21-37.

Goodley, D., & Lawthom, R. (2006). Disability studies and psychology: New allies? In D. Goodley & R. Lawthom (Eds.), *Disability & Psychology. Critical Introductions & Reflections* (pp. 1-16). New York, NY: Palgrave Macmillan.

Hansen, J. T. (2016). *Meaning Systems and Mental Health Culture.* New York: Lexington Books.

Hays, D. G. (2008). Assessing multicultural competence in counselor trainees: A review of instrumentation and future directions. *Journal of Counseling & Development, 86,* 95-101.

Hays, D. G., & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings.* New York, NY: The Guilford Press.

Hellawell, D. (2006). Inside-out: Analysis of the insider-outsider concept as a heuristic device to develop reflexivity in students doing qualitative research. *Teaching in Higher Education, 11*(4), 483-494.

Hill, N. R. (2003). Promoting and celebrating multicultural competence in counselor trainees. *Counselor Education & Supervision, 43,* 39-51.

Hipolito-Delgado, C. P., Pharaoh, T., & Hermosillo, J. (2016). Empathy and advocacy: Successfully serving communities of color. *Journal of Humanistic Counseling, 55,* 37-54.

Holcomb-McCoy, C. C. (2005). Investigating school counselors' perceived multicultural competence. *Professional School Counseling, 8,* 414-423.

Holcomb-McCoy, C. C., & Day-Vines, N. (2004). Exploring school counselor multicultural competence: A multidimensional concept. *Measurement and Evaluation in Counseling and Development, 37,* 154-162.

Kaplan, D. M., & Gladding, S. T. (2011). A vision for the future of counseling: The 20/20 Principles for unifying and strengthening the profession. *Journal of Counseling & Development,* 89, 367-372.

Ingleby, D. (2014). How 'evidence-based' is the movement for global mental health? *Disability and the Global South, 1*(2), 203-226.

Lawthom, R., & Goodley, D. (2006). Conclusions: Making enabling alliances between disability studies and psychology. In D. Goodley & R. Lawthom (Eds.), *Disability & Psychology. Critical Introductions & Reflections* (pp. 187-204). New York, NY: Palgrave Macmillan.

Leong, F. T. L. (2008). *Encyclopedia of counseling*. Los Angeles: SAGE Publications.

Lewis, J., Arnold, M. S., House, R., & Toporek, R. L. (2003). *ACA Advocacy Competencies*. Retrieved on July 27, 2016, from http://www.counseling.org/docs/competencies/advocacy_competencies.pdf

Lewis, A., Bethea, J., & Hurley, J. (2009). Integrating cultural competency in a rehabilitation curricula in the new millennium: Keeping it simple. *Disability and Rehabilitation, 31*(14), 1161-1169.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage

   Publications.

Linton, S. (1998). *Claiming disability. Knowledge and identity.* New York: New York University

   Press.

Lofaro, G. A. (1982). Disability and counselor education. *Counselor Education and Supervision,*

   21(4), 200-207.

Matthews-Juarez, P., & Juarez, P. D. (2011). Cultural competency, human genomics, and the

   elimination of health disparities. *Social Work in Public Health, 26*, 349-365.

Meekosha, H. (2011). Decolonizing disability: Thinking and acting globally. *Disability &*

   Society, 26(6), 667-682.

McCarthy, H. (2003). The disability rights movement: Experiences and perspectives of selected

   leaders in the disability community. *Rehabilitation Counseling Bulletin, 46*, 209-223.

Meekosha, H., & Shuttleworth, R. (2009). What's so critical about critical disability studies?

   Australian Journal of Human Rights, 15(1), 47-75.

Mills, C., & Fernando, S. (2014). Globalizing mental health or pathologizing the global south?

   Mapping the ethics, theory and practice of global mental health. *Disability and the*

   Global South, 1(2), 188-202.

Moss, J. M., Gibson, A. M., & Dollarhide, C. T. (2014). Professional identity development: A

   grounded theory of transformational tasks of counselors. *Journal of Counseling &*

   Development, 92, 3-12.

Neswald-McCalip, R (2001). Development of the secure counselor: Case examples supporting

   Pistole & Watkins's (1995) discussion of attachment theory in counseling supervision.

   Counselor Education & Supervision, 41, 18-27.

O'Brien, G. V. (2011). Eugenics, genetics, and the minority group model of disability: Implications for social work advocacy. *Social Work, 56*(4), 347-354.

Olkin, R. (1999). *What psychotherapists should know about disability.* New York: The Guildford Press.

Olkin, R., & Pledger, C. (2003). Can disability studies and psychology join hands? *American Psychologist, 58*(4), 296-304.

Parkinson, G. (2006). Counsellors' attitudes towards disability equality training (DET). *British Journal of Guidance & Counselling, 34*(1), 93-105.

Pedersen, P. B. (1991). Multiculturalism as a fourth force in counseling. *Journal of Counseling and Development, 70,* 6-12.

Pieterse, A. L., Evans, S. A., Risner-Butner, A., Collins, N. M., & Mason, L. B. (2009). Multicultural competence and social justice training in counseling psychology and counselor education. A review and analysis of a sample of multicultural course syllabi. *The Counseling Psychologist, 37*(1), 93-115.

Pledger, C. (2003). Discourse on disability and rehabilitation issues: Opportunities for psychology. *American Psychologist, 58*(4), 279-288.

Ratts, M. J. (2009). Social justice counseling: Toward the development of a fifth force among counseling paradigms. *Journal of Humanistic Counseling, Education & Development, 48*(2), 160-172.

Ratts, M. J., & Pedersen, P. B. (2014). *Counseling for multiculturalism and social justice. integration, theory, and application.* Alexandria, VA: American Counseling Association.

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development, 44*(1), 28-48.

Reeve, D. (2000). Oppression within the counseling room. *Disability & Society, 15*(4), 669-682.

Reeve, D. (2006). Toward a psychology of disability: The emotional effects of living in a disabling society. In D. Goodley & R. Lawthom (Eds.), *Disability & Psychology. Critical Introductions & Reflections* (pp. 94-107). New York, NY: Palgrave Macmillan.

Safran, M. A., Mays, R. A., Huang, L. N., McCuan, R., Pham, P. K., Fisher, S. K., McDuffie, K. Y., & Trachtenberg, A. (2009). Mental health disparities. *American Journal of Public Health, 99*(11), 1962-1966.

Shakespeare, T. (2013). The social model of disability. In L. J. Davis (Ed.), *The Disability Studies Reader* (pp. 215-221). New York, NY: Routledge.

Sheaffer, B. L., Sias, S. M., Toriello, P. J., & Cubero, C. G. (2008). Ego development and preferred social distance from persons with disabilities. *Rehabilitation Education, 22*(2), 147-158.

Shin, R. Q., Smith, L. C., Goodrich, K. M., & LaRosa, N. D. (2011). Attending to diversity representation among council for accreditation of counseling and related educational programs (CACREP) master's programs: A pilot study. *International Journal for the Advancement of Counselling, 33*, 113-126.

Sim Chun, K. Y., & Singh, A. A. (2010). The bisexual youth of color intersecting identities development model: A contextual approach to understanding multiple marginalization experiences. *Journal of Bisexuality, 10, 429-451.*

Singh, A. A., & Sim Chun, K. Y. (2010). "From the margins to the center": Moving towards a resilience-based model of supervision for queer people of color supervisors. *Training and Education in Professional Psychology, 4*(1), 36-46.

Singh, A. A., Urbano, A., Haston, M., & McMahon E. (2010). School counselors' strategies for social justice change: A grounded theory of what works in the real world. *Professional School Counseling, 13*(3), 135-145.

Smart, J.F., & Smart, D.W. (2006). Models of disability: Implications for the counseling profession. *Journal of Counseling & Development, 84*, 29-40.

Smith, L., Foley, P., & Chaney, M. (2008). Addressing classism, ableism, and heterosexism in counselor education. *Journal of Counseling & Development, 86*, 303-309.

Substance Abuse and Mental Health Services Administration. (2014). *Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-49, HHS (Publication No. SMA 14-4887). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sue, D. W., Arredondo, P., & McDavis, R. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20*, 64-88.

Swain, J., Griffiths, C., & French, S. (2006). Counselling with the social model: Challenging therapy's pathologies. In D. Goodley & R. Lawthom (Eds.), *Disability & Psychology. Critical Introductions & Reflections* (pp. 155-169). New York, NY: Palgrave Macmillan.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race and ethnicity. A supplement to mental health: A report of the Surgeon General.* Rockville, MD: Author.

U.S. Department of Health and Human Services. (2005). *The Surgeon General's call to action to improve the health and wellness of persons with disabilities.* Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General.

US Substance Abuse and Mental Health Services Administration. (2014). *Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-49, HHS (Publication No. SMA 14-4887). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Vera, E. M., & Speight, S. L. (2003). Multicultural competence, social justice, and counseling psychology: Expanding our roles. *The Counseling Psychologist, 31,* 253-272.

Vereen, L. G., Hill, N. R., & McNeal, D. T. (2008). Perceptions of multicultural counseling competency: Integration of the curricular and the practical. *Journal of Mental Health Counseling, 30(3)*, 226-236.

Vinson, T. S., & Neimyer, G. J. (2000). The relationship between racial identity development and multicultural counseling competency. *Journal of Multicultural Counseling and Development, 28*, 177-192.

Watt, S.K., Curtis, G., Drummond, J., Kellogg, A., Lozano, A., Tagliapietra, G., & Rosas, M. (2009). Privileged identity exploration: Examining counselor trainee's reactions to difficult dialogues. *Counselor Education & Supervision, 49*, 86-105.

Wilkinson, R. T. (2011). Increasing counselor self-awareness: The role of cognitive complexity and metacognition in counselor training programs. *Alabama Counseling Association Journal, 33*(1), 24-32.

World Health Organization. (WHO, 2011). World report on Disability. (Publication No. 62783). Retrieved on July 27, 2016, from

http://documents.worldbank.org/curated/en/665131468331271288/pdf/627830WP0World

00PUBLIC00BOX361491B0.pdf

Ziomek-Daigle, J., & Christensen, T. M. (2010). An emergent theory of gatekeeping practices in

counselor education. *Journal of Counseling & Development, 88,* 407-415.

Michele Rivas, P-LMHC NCC

211 ½ Howard St. Syracuse, NY 13203 - (631) 455-1581- mlopez02@syr.edu

EDUCATION

PhD in Counseling and Counselor Education (CACREP Accredited)   **Anticipated May 2017**
Syracuse University, School of Education
Advisor: Dr. Nicole R. Hill
Dissertation topic: *"The Development of Disability Competence: A Qualitative Investigation of
       Licensed Professional Counselors' Perceptions"*
Committee: Dr. Nicole R. Hill (Chair), Dr. Derek Seward, Dr. Beth Ferri.
Certificate of Advanced Study, Disability Studies   **May 2017**
Future Professoriate Program Certificate   **May 2017**

Master's of Science: Clinical Mental Health Counseling (CACREP Accredited)   **May 2013**
Long Island University

Licenciado en Psicología Clínica Dinámica   **January 2006**
Universidad Central de Venezuela, Caracas - Venezuela
Thesis – *"Study of the Rorschach Comprehensive System's Cognitive Structural Variables in a
Caracas's Non-patient Adult Sample"* Mention earned: Publication.

PROFESSIONAL CREDENTIALS

Licensed Mental Health Counselor-Permit holder, P95150, New York State
National Certified Counselor, ID 343471, National Board for Certified Counselors
Licensed Psychologist, License #5905, Venezuelan Psychologists Federation

PUBLICATIONS

Refereed:

Lopez (Rivas), M. (2015). Developmental disability, sexuality, and counseling: A call for action
       and ecological implications. *Journal of the Pennsylvania Counseling Association*, *14,* 19-
       27.

Book Chapters:

Vereen, L., Hill, N. R., & **Lopez (Rivas), M.** (2015). African American Athletes and Higher
       Education. In M. A. Shillingford-Butler & J. Curry (Eds.), *The Journey Unraveled:
       College & Career Readiness of African American Students.* NY: Lexington Books.

Lopez (Rivas), M. (2015). Combining Feminist Group Supervision with the Foci Areas of the
       Discrimination Model. In M. Luke & K. M. Goodrich (Eds.). *Group Work Experts Share*

Their Favorite Activities for Supervision. Alexandria, VA: Association for Specialists in Group Work.

Under Review:

Rivas, M. & Hill, N.R (under review). Counseling Clients with Disabilities: A Phenomenological Study of Trainees' Experiences. *Counselor Education and Supervision.*

Peters, H.C. & **Rivas, M.** (in review). Affirmative client care: Reconciling evidence-based practices within humanistic engagement. *Journal of Humanistic Counseling.*

Peters, H.C. & **Rivas, M.** (in revision). The Self-Model of Humanistic Supervision. *Journal of Humanistic Counseling.*

Manuscripts in Preparation:

Rivas, M., Hill, N. R., Peters, H. C., & Vereen, L. (in preparation). Multicultural training for counselors: A qualitative investigation of students' experiences. *Journal of Multicultural Counseling and Development.*

Rivas, M. (in preparation). Indigenous street children: Contested narratives of mental health and disability in indigenous Ecuador. *Disability Studies Quarterly.*

Rivas, M. & Vereen, L. (in review). Group Counseling and Disability: A Critical Review. *International Journal for the Advancement of Counselling.*

PRESENTATIONS

National/International:

Hill, N. R., Vereen, L., & **Rivas, M.** (March, 2016). *Student Athlete Well-Being: Creating Synergy between Wellness and Career Readiness.* (Educational session) American Counseling Association and Canadian Counselling and Psychotherapy Association Conference. Montreal, Canada.

Levine, C., Peters, H. C., **Rivas, M.**, Lee, A., Luke, M., & Seward, D. (March, 2016). *Advocacy through Exploration: Group Dialogues for Strengthning Counselor Identity.* (Poster Presentation) American Counseling Association and Canadian Counselling and Psychotherapy Association Conference. Montreal, Canada.

Rivas, M. (September, 2015) *A Structured and Systemic Model for Literature Reviews: Cultivating Success for Emergent Scholars.* (ACES INFORM session) Association for Counselor Education and Supervision Conference. Philadelphia, Pennsylvania.

Lee, A. & **Rivas, M.** (September, 2015) *Fostering Cultural Conversations through Safety and Engaged Pedagogy.* (Roundtable Session) Association for Counselor Education and Supervision Conference. Philadelphia, Pennsylvania.

Rivas, M. (September, 2015) *Cultivating Culturally Relevant Pedagogy: A Phenomenological Study of Counselors' Lived Experiences Counseling Disability. (Educational session)* Association for Counselor Education and Supervision Conference. Philadelphia, Pennsylvania.

Rivas, M. & Lee, A. (September, 2015) *Intersectionality in Group Supervision: A Feminist Approach to Engaged and Transformative Pedagogy.* (Roundtable Session) Association for Counselor Education and Supervision Conference. Philadelphia, Pennsylvania.

Hill, N, Kerns, L., Vereen, L., Seward, D., **Rivas, M.**, & Peters, H. (September, 2015) *Privacy, Security, and Encryption: Challenges and Strategies for Ensuring HIPAA Compliance.* (Presentation Panel) Association for Counselor Education and Supervision Conference. Philadelphia, Pennsylvania.

Luke, M. & Goodrich, K. (Editors) and SU Contributors (**M. Rivas** among others). (September, 2015). Group Work Experts Share Their Favorite Supervision Activities. (Book Signing) Association for Counselor Education and Supervision Conference. Philadelphia, Pennsylvania.

Rivas, M. (June, 2015). *Groupwork and People with Disabilities, A Critical Examination of the Counseling Literature.* (Poster Presentation) American Mental Health Counseling Association Conference. Philadelphia, Pennsylvania.

Rivas, M. (July, 2014) *Attachment Styles and Clinical Supervision: A research approach and potential practical suggestions for clinical supervisors.* (Educational Session) 10th International Interdisciplinary Conference on Clinical Supervision. Adelphi University. Garden City, New York.

Rivas, M. (March, 2014) International Student Panel. Presented at the American Counseling Association International Conference. Honolulu, Hawaii.

Regional:

Rivas, M. & Peters, H. C. (October 2016). *Contested Narratives in Counselor Education: Multicultural Humanism or Humanism in the Global South.* (Poster Session) Southern Association for Counselor Education and Supervision Conference. Louisiana, New Orleans.

Rivas, M. & Hill, N. R. (October 2016). *Disability in Multicultural Training: A Phenomenological Study of Counselors' Lived Experiences.* (Poster Session) Southern Association for Counselor Education and Supervision Conference. Louisiana, New Orleans.

Hill, N. R., Vereen, L. G., & **Rivas, M.** (October 2016). *Strengthening the Resilience of Student-Athletes: Contributions of Counselor Education Programs.* (Rountable) Southern Association for Counselor Education and Supervision Conference. Louisiana, New Orleans.

Peters, H. C., Lustica, H., Smith, A., **Rivas, M.** (September 2016). *Panel for Graduate Student Leadership and Development*. North Atlantic Association for Counselor Education and Supervision. Syracuse, New York.

Rivas, M., Hill, N. R., Peters, H. C., & Vereen, L. G. (September 2016). *Multicultural Training for Counselors: A Qualitative Investigation of Students' Experiences.* (Poster Session). North Atlantic Region Association for Counselor Education and Supervision Conference. Syracuse, New York.

Rivas, M. & McEachern, M. (September, 2014). *Igniting the power of love: A review of the literature in LGBT in people with Disabilities*. North Atlantic Region Association for Counselor Education and Supervision Conference. Providence, Rhode Island.

Thaxton, S., Luke, M. & **Rivas, M.** (September, 2014). *Consensual Qualitative Research: Analysis of Critical Incidents in Counselor Educators' Research Collaboration*. North Atlantic Region Association for Counselor Education and Supervision Conference. Providence, Rhode Island.

Mariska, M., **Rivas, M.,** & Denicker, A. (September, 2012). *Using Strength based Assessment in Experiential Learning Assignments.* North Atlantic Region Association for Counselor Education and Supervision Conference. Niagara Falls, New York.

Local:

Rivas, M. (October, 2015). *Indigenous Street Children: Contested Narratives of Mental Health and Disability in Indigenous Ecuador.* 2015 University of Rochester Disabilities Studies Cluster Symposium. Rochester, New York.

Lopez (Rivas), M. & Thaxton, S. (November, 2014). *Empowering the Right to Love: A Call for Professional Collaboration in the Field of People with Developmental Disabilities.* (Educational Session) 46th Annual Pennsylvania Counseling Association Conference. State College, Pennsylvania.
Granger, E., **Lopez (Rivas), M.**, & Yu, X. (March, 2013) *Intercultural Communication: Understanding our International Students*. Presented at the Resident Advisor Diversity Drive-In Conference at Syracuse University. Syracuse, New York.

INVITED LECTURER

Rivas, M. (October, 2016). *Multicultural Reflexivity*. Department of Psychology and Counseling. Alfred University. Alfred, NY.

Rivas, M. (April, 2016). *Disability and Sexuality in Counseling and Counselor Education.* Plymouth State University Diversity Institute. Plymouth, New Hampshire.

Rivas, M. (Fall, 2015). *Convergence of Professional Counseling, Culture, Ecology, and Ethical practice.* Professional Orientation and Ethics class. Department of Counseling and Human Services. Syracuse University. Syracuse, New York.

Rivas, M. (Fall, 2015). *Diagnosis and Assessment in Counseling.* Professional Orientation and Ethics class. Department of Counseling and Human Services. Syracuse University. Syracuse, New York.

Rivas, M. & Lee, A. (Spring, 2015). *Disability and Intersectionality in Multicultural Training.* Social and Cultural Dimensions of Counseling. Department of Counseling and Human Services. Syracuse University. Syracuse, New York.

Rivas, M. (Spring, 2015). *Projective assessment in Counseling and the Rorschach inkblot test.* General Counseling Methods class. Department of Counseling and Human Services. Syracuse University. Syracuse, New York.

Rivas, M. (Summer 2014). *Disability in Multicultural Training.* Social and Cultural Dimensions of Counseling. Department of Counseling and Human Services. Syracuse University. Syracuse, New York.

RESEARCH-RELATED EXPERIENCE

National:
Lead Researcher in Qualitative Project   **March 2016 – present**
- I am collaborating with two faculty members and a doctoral student in a qualitative study that uses Consensual Qualitative Research method to explore the students' experiences related to their multicultural training.

Doctoral Research Apprenticeship Project   **March 2015 – March 2016**
- Designed and conducted a phenomenological study with Dr. Nicole R. Hill about counseling trainees' lived experiences in counseling clients with disabilities and receiving training to work with this population in their graduate programs. The completion of this project was one component for my advancement to doctoral candidacy.

International:
DATANALISIS Caracas-Venezuela   **April 2008- March 2010**
- I worked as a Content Analysis Professional Consultant, and managed simultaneous qualitative projects in different areas as health and massive consumption through multiple field methodologies.

REGIUS GROUP Venezuela & Panama   **June 2007- October 2007**

- I worked as a Qualitative Consultant and conducted qualitative projects related to cultural research and consumption habits in inhabitants of Caracas and Ciudad de Panama through the use of ethnography and other qualitative methodologies.

EMEVENCA Dominican Republic   **April 2005- March 2007**
- I worked as a Qualitative Consultant and conducted qualitative projects related to cultural research and consumption habits in inhabitants of Caracas and Dominican Republic through the use of ethnography and other qualitative methodologies.

RESEARCH INTERESTS

Multicultural Counselor Preparation   Disability Studies and Rehabilitation Counseling
Multicultural Competence   Multiculturalism and the Global South
Disabled People of Color and Family   Disabled People of Color and Mental Health
Intersectionality in Multicultural Education   Global Mental Health

TEACHING EXPERIENCE

Instructor of Record
COU 727 - Foundations of Clinical Mental Health Counseling   Spring 2017
COU 790 - Internship in Counseling   Fall 2016
COU 750 - Practicum in Counseling   Fall 2015
COU 101 - Developmental Issues in College Students   Fall 2015
COU 101 - Developmental Issues in College Students   Spring 2015

Co-Instruction/Teaching Assistant
COU 723- Psychological, Social, & Cultural Aspects of Disabilities   Fall 2016
COU 614- Group Counseling and Theory   Spring 2016
COU 790 - Internship in Counseling   Summer 2015
COU 101 - Developmental Issues in College Students   Fall 2014
COU 790 - Internship in Counseling   Summer 2014
COU 626 - Social and Cultural Dimensions of Counseling   Spring 2014

Doctoral Clinical Supervisor
COU 750 - Practicum in Counseling   Fall 2013-present
COU 790 - Internship in Counseling   Spring 2015 - present

HONORS AND RECOGNITIONS

Outstanding Graduate Student Award   September, 2016
Awarded by the North Atlantic Region Association for Counselor Education and Supervision

Emerging Leader   September, 2015
Awarded by the Association for Counselor Education and Supervision

Inductee   April 2014-present

Chi Sigma Iota International Honor Society

Graduate Symbolic Degree Recipient   May, 2013
Awarded by Long Island University

Emerging Leader   September, 2012
Awarded by the North Atlantic Region Association for Counselor Education and Supervision

Aviva Bershaw Award for Dedication and Commitment
to the Profession of Counseling   May, 2012
Awarded by Long Island University

GRANTS

Graduate Student Travel Grant ($800)   September, 2016
Office of the Dean, School of Education, Syracuse University
Department of Counseling and Human Services, Syracuse University
- Funds will be used to attend and present at the SACES conference, Louisiana

Graduate Student Travel Grant ($800)   September, 2015
Office of the Dean, School of Education, Syracuse University
Department of Counseling and Human Services, Syracuse University
- Funds used to attend and present in the ACES conference, Pennsylvania

Graduate Student Travel Grant ($800)   September, 2014
Office of the Dean, School of Education, Syracuse University
Department of Counseling and Human Services, Syracuse University
- Funds used to attend and present in the NARACES conference, Rhode Island

Graduate Student Travel Grant ($900)   March, 2014
Office of the Dean, School of Education, Syracuse University
Department of Counseling and Human Services, Syracuse University
- Funds used to attend and present in the ACA conference, Hawaii

SERVICE AND LEADERSHIP

Editorial Staff, *Journal of Counselor Preparation and Supervision*   Spring 2017

Committee Member, *ACES Social Justice and Human Rights Committee*   Spring 2017

Committee Member, *Search Committee for Tenure-Track position in*   Fall 2016 – Spring 2017
Department of Counseling and Human Services, Syracuse University

Ad Hoc Reviewer, *Journal of Specialists in Group Work*   Summer 2016

Co-Editor, *NARACES Graduate Student Bulletin*   Summer 2016

Program Reviewer, *2016 NLPA Latino Conference*   Fall 2015

Member, *Exhibit/Sponsors Committee*   Summer, 2015
2015 Association for Counselor Education and Supervision Conference

Vice-President, *Chi Sigma Iota, Sigma Upsilon chapter*   (2014-2015)
Chi Sigma Iota International Counseling Honor Society

Member, *Teaching and Leadership Curriculum Committee*   (2014-2015)
Syracuse University, School of Education

Family Crisis Counseling Curriculum development for   December 2011- August 2013
parents of children with developmental disabilities
Youth Adult Institute, New York, New York

Counselor Volunteer for Hispanic clients with disabilities   May 2010- August 2010
Pilgrim Psychiatric Center, Brentwood, New York

WORK EXPERIENCE

Professional Counselor (limited permit) – Private Practice   **May 2016-present**
Syracuse, New York
• Provide bilingual counseling service to individuals, couples, and families

Graduate Assistant - Syracuse University   **August 2014-present**
Department of Counseling and Human Services
• Serve as teacher assistant for classes taught in the department
• Supervise the clinical experiences of students enrolled in Practicum and Internship

Professional Counselor (limited permit)   **August 2013-present**
Brownell Center for Behavioral Health, Syracuse, NY
• Provide counseling services for adults, adolescents and families in English and Spanish
• Plan and deliver interventions and referrals according to client's needs
• Create and implement treatment plans for clients

Graduate Assistant – Mentorship Program Coordinator   **August 2013-May 2014**
Slutzker Center for International Services – Syracuse University
• Delivered presentations to SU's international freshmen about the Connections program
• Coordinated, trained and supervised the group of mentors

Bilingual Crisis Counselor **– Family Services**   **October 2011-August 2013**
YAI National Institute for People with Disabilities, Kew Gardens, NY 11415
• Provided parents with In-Home behavioral crisis intervention in English and Spanish
• Offered psychoeducation to parents of children with disabilities to effectively handle
misbehaviors and emotional difficulties at home

- Connected families with additional services within YAI or other agencies

Intern - Social Security's National Unit for Infantile Psychiatry   **January 2005-July 2005**
Caracas, Venezuela
- Performed emotional and neurological assessments and collaborated with multidisciplinary teams in the development of treatment
- Provided counseling to adolescents and their families in Spanish
- Completed psychological evaluations and designed treatment recommendations
- Conducted follow up sessions to evaluate progress and provide referrals for additional services

Intern - Mental Health Center   **September 2004-January 2005**
Central University of Venezuela
- Performed emotional and neurological assessments and prepared treatment plans in conjunction with staff (Psychiatrists and Psychologists)
- Provided counseling to children, adolescents and adults, and provided informational sessions and counseling to families
- Conducted follow up sessions to evaluate progress and provide referrals for additional services

PROFESSIONAL AFFILIATIONS

American Counseling Association	2013-present
Association for Counselor Education and Supervision	2013-present
Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling	2016-present
Association for Multicultural Counseling and Development	2016-present
North Atlantic Association for Counselor Education and Supervision	2013-present
Southern Association for Counselor Education and Supervision	2016-present
International Association of Marriage and Family Counselors	2016-present
Society for Disability Studies	2014-present
American Rehabilitation Counseling Association	2016-present
Association for Humanistic Counseling	2016-present
Chi Sigma Iota International Counseling Honor Society	2013-present
The C. G. Jung Foundation of New York	2014-present