FEATURE

Disability and Clinical Competency: An Introduction

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Persons with disabilities are often overlooked as a part of the tapestry of diversity. However, this population spans across every ethnicity, gender, sexual orientation, age, religion, and socio-economic group ever known. Approximately one of every five Americans has a disability, comprising nearly twenty percent of our nation's population (2000 Census). It is evident that persons with disabilities, particular people of color with disabilities, have less access to, and availability of, mental health services. (Surgeon General, 1999.) Section 2.01(b) of the APA Ethics Code (American Psychological Association, 2002,) supports an affirmative need as a profession to develop disability-related competence. This article is an attempt to introduction practitioners to disability and clinical competency.

As practitioners, we often have not been given adequate, if any, instruction on now to deliver culturally-competent clinical services to persons with disabilities. This oversight might be attributed to our society historically viewing disability from a medical model (Leeds Metropolitan University, 2005). This model states that disability represents a defect or loss of function that resides in the individual. In turn, medical doctors have treated persons with disabilities exclusively with surgery and/or medication. These individuals often are viewed as "scientific subjects" and are probed as if they are inanimate objects, communicating an unspoken message that they are not fully human. Moreover, whatever its outcome, this medical treatment is seen as "good enough" practice and worthy of appreciation by the individual as an attempt to improve one's life.

Persons with disabilities traditionally have experienced systematic institutional victimization from all aspects of society including, but not limited to, the medical profession, the educational system and the workforce. The mental health of these individuals often is ignored (Vash & Crewe, 2003). In rare instances when mental health treatment has been sought, practitioners tend to focus on the medical aspects of the person, depersonalizing the individual. Sadly, unbeknownst to the practitioner, this inclination can lead to the revictimization of the client. Moreover, many persons with disabilities have internalized society's perceptions of being "less than" and often have created an image of being "Super Human" in order to combat their feelings of inadequacy. Persons with disabilities often believe that they need to prove that they belong as members of society and overcompensate by portraying that they do not need support in any way.

Recently, a shift away from the medical model to the minority model is emerging (Gallardo, 2005). The minority model views disability as an external problem involving an environment that fails to accommodate the needs of individuals with disabilities. This model emphasizes lifting the responsibility of accommodation from the individual attempting to conform to societal norms to a society that needs to accommodate them as individuals. As practitioners, we can aid in the facilitation of this shift by "humanizing" disability and incorporating simple yet important strategies into our everyday practice.

First, practitioners need to evaluate their own comfort level when working with persons with disabilities. Just as with other clients, if practitioners do not believe that they can benefit others because of their biases, referring may be the best practice.

Second, practitioners need to be aware that the per-

son may not seek treatment primarily because of the disability. For many individuals with disabilities, especially those with lifelong impairments, having a disability is a "part" of who they are — not entirely "who" they are. Indeed, the disability most likely has had a tremendous impact on their life. However, disability may not be the presenting problem. Practitioners should be aware that if focus is placed on the disability, the client might not continue treatment. These individuals seek treatment to explore life issues as other clients do, such as events with family and work. They may feel insulted if practitioners deny that they have lives beyond disability. Likewise, if the practitioner completely ignores a client's disability, the client may not continue treatment, perceiving that the practitioner is denying and/or uncomfortable with who they are.

So what can practitioners do to deliver competent treatment to clients with disabilities? Understanding a clients development is necessary for practitioners to support their clients fully. Following is an introduction to the Disability Identity Development Model (Gibson, 2005). This model was developed to facilitate a practitioners understanding for persons with life-long disabilities while increasing their ability to provide competent treatment to this underserved population.

As with other multicultural identity models of development, the Disability Identity Model is intended to promote a practitioner's understanding of a client's identity development by giving insight into their possible perceptions and struggles. However, practitioners should not assume that all clients with disabilities must fit into a particular stage. Identity development of persons with disabilities can be fluid. Thus, a client may have reached Stage 3 - Acceptance but may revert to Stage 2 - Realization when faced with job discrimination or lack of dating partners. The "Why me?" and anger can resurface, creating much frustration for clients since they may have thought that they were beyond such feelings. Moreover, other aspects of the client, e.g., ethnicity, gender, sexual orientation, and so forth, should not be ignored. Rather, practitioners should integrate what they know about other cultures and incorporate it into treatment. Again, persons with disabilities come from all walks of life. Disability is a part of who they are, not the sum of who they are.

As practitioners begin to consider the identity development of persons with disabilities within clinical practice, the following communication strategies are recommended to assist in providing competent treatment to this population:

Incorporate all aspects of the individual (e.g., gender, ethnicity, sexual orientation, etc.) into treatment.

Use person-first language. Language empowers.

Speak directly to the person rather than through a companion or sign language interpreter. Although, at times, the care provider needs to be included in a session/meeting, people with disabilities have the right to expect privacy, confidentiality, and to participate in decision making regarding their mental health care.

Do not assume a person with a physical disability is either hard of hearing or has a cognitive disability as well. Speaking **louder** is not typically necessary or more helpful.

When meeting a person with a visual disability, always identify yourself and others who may be with you. When conversing in a group, remember to identify the person to whom you are speaking.

Treat adults as adults. Address people who have disabilities by their first names only when extending the same familiarity to all others.

Listen attentively when you are speaking with a person who has difficulty speaking. Be patient and wait for the person to finish, rather than correcting or speaking for the person. If necessary, ask short questions that require short answers, a nod or shake of the head. Never pretend to understand if you are having difficulty doing so. Instead, repeat what you have understood and allow the person to respond. The response will clue you in and guide your understanding.

Disability Identity Development (Gibson, 2005)

STAGE 1 **Passive Awareness:** First part of life 0-? Can continue into adulthood	STAGE 2 **Realization:** Often occurs in adolescence/early adulthood	STAGE 3 **Acceptance:** Adulthood
• No role model of disability	• Begins to see self as having a disability	• Shift focus from "being different" in a negative light to embracing self
• Medical needs are met	• Self-Hate	• Begins to view self as relevant; no more no less than others
• Taught to deny social aspects of disability	• Anger: Why me?	• Begins to incorporate others with disabilities into life
• Disability becomes silent member of family	• Concerned with how others perceive self	• Involves self in disability advocacy and activism
• Co-dependency/" Good-Boy/Good-Girl"	• Concerned w/appearance	• Integrates self into majority (able-bodied) world
• Shy away from attention	• "Superman/woman" Complex	

• Will not associate w/others w/disability		

This article has been an introduction into disability and clinical competency. It needs to be noted that though useful, practitioners cannot attribute the understanding of an individual based solely on the created identity development constructs that we use as tools. Human beings are much more complex. As practitioners, we need to consider the whole person if we have a chance of providing clinical competent care.

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