‘We Move Together’:

Bringing Disability Justice to Counselling Practice for the Benefit of All Clients

by

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Abstract

There is little attention paid to the topic of disability in counselling and psychology, whether it is in relation to the experience of disabled people themselves in counselling sessions, or to developing disability competencies as practitioners. As a result of this, ableism, sanism, and neurotypical bias remain largely unaddressed in the counselling field. The aim of this capstone is to investigate the ways that Disability Justice can be brought to counselling - as both a framework and a way of working - in order to support disabled, Mad, and neurodivergent clients, as well as all clients. Themes identified in the literature include: clients' experiences in counselling (highlighting the reality of concurrent harm and benefit in the counselling room); therapy effectiveness (revealing an emphasis on CBT therapies and evidence of its efficacy - with adaptations - as well as evidence for the use of other therapies, and the need for further study); and the creative possibilities of integrating Disability Justice into practice. I propose that Disability Justice can assist us in examining ourselves and our frameworks more clearly; understanding our disabled, Mad, neurodivergent clients in context; attending to the therapeutic relationship; and building a repertoire of culturally-responsive, accessible clinical interventions of benefit to all clients.

Keywords: ableism, disability justice, mad, neurodivergent, sanism

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> *All bodies are unique and essential. All bodies are whole. All bodies have strengths and needs that must be met. We are powerful not despite the complexities of our bodies, but because of them. We move together, with no bodymind left behind. This is disability justice. (Sins Invalid, 2019, p. 12)*

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Chapter One: Opening the Door to Disability, Madness, and Neurodivergence

Despite the dedication of Olkin (2007; 2015; 2020) and other disabled psychologists, “psychology has not opened the door to disability” (Brodt, 2021, p. 4). In tracing the links between disability and therapy, Olkin (2020) found that most evidence-based studies exclude disabled people, leading to a lack of shared knowledge in the profession as to what is most supportive to disabled clients with a range of needs. Multiple authors point to the neglect of the disability experience in the counselling profession, with subsequent lack of quantitative evidence, firsthand qualitative accounts from disabled clients, practice recommendations, and practitioner training (Öksüz & Brubaker, 2020; Rivas, 2020). On the other hand, significant work has been done in social psychology to highlight the attitudinal and environmental barriers experienced by disabled people (Nario-Redmond, 2019). Additionally, the sub-field of Rehabilitation Counselling (RC), makes important contributions to practice, and is slowly adopting principles of social justice even as it wrestles with its own ableist foundations (Hartley & Tarvydas, 2022; Imrie, 1997). The inverse is less true - there is little acknowledgment of disability or ableism in multicultural / cross-cultural approaches to counselling generally, or as one of multiple social justice crossroads (Andrews et al., 2021). As a result of this, little information exists regarding the extent to which practitioners are equipped to mitigate and address ableism in counselling - including reflecting on their own complicity in ableism generally, addressing ableist microaggressions in sessions, or engaging in repair during instances of rupture with disabled clients.

The lessons gleaned from disabled clients and practitioners, social psychology, RC, and

Disability Justice have so far *not* informed the overall development of practitioners' therapeutic competencies. To date, there are no widely adopted evidence-based practices for working with disabled clients, including aging disabled clients (Grenier et al., 2020; Olkin, 2020). As Brodt (2021) puts it: "it [is] necessary for all of psychology to become disability competent…it is no longer acceptable to suggest that anything related to a disabled person is a job for specialists" (p. 4). This paper addresses a major gap in the field by bringing Disability Justice (defined in Chapter Two) more fully within the purview of counselling practice.

Background of the Topic

There is a dearth of research on the topic of disability in counselling and psychology, on the experience of disabled people themselves in counselling sessions, and on developing disability competencies as practitioners (including strategies for intervening on ableism). Psychology's and counselling's limited understanding of disability is notable, given that most people will experience disability either temporarily or permanently in their lifetime, or will age-into-disability (Grenier et al., 2020). To the extent that disability can be quantified, disabled people comprise the largest 'minority' group in the US with about 1 in 4 Americans experiencing disability (Centers for Disease Control and Prevention, 2023). Approximately 1 in 5 Canadians over the age of 15 is disabled (Morris, et al., (2018), and about 1 in 6 people worldwide experiences disability (World Health Organization, 2023). Due to systemic barriers, disabled people and their caregivers often navigate significant disadvantages (World Health Organization, 2023). In short, the vast majority of people will closely encounter disability in their lifetime.

Disabled, Mad, and neurodivergent people are more likely than their nondisabled counterparts to experience greater mental and emotional distress, as well as significant inequities in accessing appropriate therapeutic support (Longhurst & Full, 2023). Evidence suggests that

inequities exist, in part, because care providers (e.g., nurses, doctors, psychologists) who work with disabled people often have little meaningful contact with disabled people in their everyday lives (Andrews et al., 2021). This leads to implicit ableist bias and distortions (Olkin, 2020). Multiply-marginalized disabled people (for example, trans or racialized disabled people) are even more likely to face discrimination in health care (Andrews et al., 2021).

Relatedly, disabled people are more likely to experience compromised overall health due to abuse, isolation, and active exclusion from societal participation (World Health Organization, 2023). Not only this, McGibbon (2021) concludes that mental-emotional distress is higher for people in nondominant groups (e.g. racialized, immigrant, queer, trans, and aging communities, among others). The author illustrates the ways that systemic oppression, specifically in the context of neoliberal wealth accumulation and material deprivation, *causes disablement and distress* amongst humans and threatens the health of the planet (McGibbon, 2021). This suggests complex and multi-directional linkages between disability, marginalization, and mental-emotional distress: oppression literally causes disability across nondominant groups; conversely, disabled people are oppressed due to ableism, which causes suffering; and all people of nondominant groups are more likely to experience mental-emotional distress. Therefore, there is a great need for accessible, justice-led, life-affirming, and culturally-relevant therapeutic support for disabled clients across social locations.

Purpose Statement

Ableism, sanism, and neurotypical bias remain largely unaddressed in the counselling field. This impacts disabled, Mad, and neurodivergent clients, multiply-marginalized clients across social locations, as well as nondisabled clients. The purpose of this research is to investigate the ways that Disability Justice can be brought to counselling, in order to support

disabled, Mad, and neurodivergent clients, as well as all clients. Two research questions guide this inquiry:

1. How can counsellors incorporate Disability Justice into their practice, as both a *framework* and a *way of working?*
2. How can Disability Justice practices be of benefit to those most impacted by ableism (disabled clients) *as well as* to nondisabled clients, and counsellors?

This paper is written for all counsellors who wish to foreground their cultural humility as it relates to disability, and to deepen their understanding, and their ways of working, with all clients. This paper is also written for disabled clients and counsellors, with the wish that they might see a bit of themselves reflected in these pages.

Theoretical Framework

Counselling research which uses a critical lens of disability or a social justice approach is exceedingly rare, occluding the social, cultural, and material conditions, and identity-based aspects, of the disability experience. To more fully account for these aspects, I will be using a Critical Disability Studies theoretical framework to guide this study, with help from subfields of crip theory and Mad studies. These fields have helped shape my ideas about the disability experience, have informed my approach to searching the literature (including grey literature and community knowledge(s)), as well as informed my interpretation of findings.

Critical Disability Studies

Critical Disability Studies (CDS), which began in the Global North (primarily in the UK, US, and Canada), takes disability to be a social, political, and cultural phenomenon (Linton, 1998). Critical Disability Studies originates from earlier disability studies research as well as from grassroots rights-based movements, beginning in the 1960's, which sought to actualize full

rights and citizenship for disabled people (Oliver, 1990). Critical Disability Studies departs from earlier activism and scholarship in that it proposes solutions beyond reforms to neoliberal policy (Meekosha & Shuttleworth, 2009) and beyond inclusion ('add-and-stir' models which are argued to be assimilationist in intent (Thorneycroft, 2020)). This body of work engages deeply with lived experience and cultural production - art, performance, narratives, archives - as part of both the process and result of study (Chandler et al., 2018; Eales & Peers, 2016). Scholars in CDS argue that non-normative bodyminds can possess a transgressive and generative quality (Overboe, 1999; Goodley et al., 2019). They can also be a resource for life's wisdoms, informing our understandings of human value, embodiment, and the nature of community (Rice et al., 2018). Disability can be a signifier of inequity or precarity (Goodley et al., 2019), or in the case of disability arts, culture, scholarship, and justice-doing, disability can hold the promise of something affirming or creative (Goodley et al., 2019).

Critical Disability Studies draws from, and is in-step with, other postmodern fields of study, including queer theory (Kafer, 2013; McRuer, 2006) and feminist theory (Crow, 1996; Morris, 1993). Black and Indigenous scholars (Meekosha, 2011; Schalk & Kim, 2020) and other disabled scholars of colour (Ghai, 2012) have pointed to the dominance of white, Global North perspectives in disability studies. These and other authors are centering the lived experiences of racialized disabled people, including materialist-feminist analyses of the social and economic conditions impacting these group's lives (Erevelles, 2011; Meekosha, 2011).

Crip Theory and Mad Studies

Crip theory emerges from CDS, grassroots organizing, and creative projects shaped by disabled people, some of whom are also queer. Seminal writings on crip theory by McRuer (2006) and Sandahl (2003) draw heavily from queer theory. Crip theory utilizes case study, and

the study of cultural products such as movies and T.V shows, to trace *compulsory ablebodiedness* - the expectation that "normalcy" and "able-bodiedness" are what everyone wants. This universal desire is legible in everyday questions like: "Wouldn't you rather that your child had been born normal?" or "Don't you want a cure?" which demand narrow, affirmative responses, despite these ideals being impossible for anyone to fully achieve. McRuer (2006) traces the everyday queer and crip practices of *resistance* to compulsory able-bodiedness which occur in the context of neoliberal capitalism. Kafer (2013) and others have added to the mix 'compulsory able-mindedness,' and collective resistances to this.

Mad studies is rooted in the Mad community itself, in people who have been labeled non-consensually as, treated as, or oppressed as crazy (Sinclair et al., 2023). These may be people who are currently consumers, past survivors, or ex-patients of the 'psy' (psychiatry, psychology, etc) fields. Mad studies draws from lived experience, scholarship, and subjugated knowledges to challenge dominant discourses of the psy fields, approaching questions of mental, psychological, and behavioural difference with a critical eye. This marks its synergy with other movements-turned-academic disciplines. Also like other disciplines, Mad studies has typically "whitewashed Mad Studies history, ontology, and phenomenology… harmfully centring white, middle class…patriarchal and colonial frameworks and ideologies" (p. 3).

Thorneycroft (2020) writes that there are overlaps in the lived experiences of crip and Mad people, and of course there are people who experience both disability and Madness. Overlaps can be seen in histories of subversion of the 'norm' in both groups, such as reclaiming terms ("crip," "Mad") and engaging in everyday practices, political action and protest, and/or art that open up new ways of thinking and being (Thorneycroft, 2020). Overlaps in academic fields of Mad studies and crip theory highlight the ways in which those who experience disability,

neurodivergence, and Madness are linked under the disciplinary system(s) of compulsory ablebodiedness, compulsory ablemindedness, and compulsory sanity. These interlocking systems require us to agree with the sentiment that able-bodied, sane, and neurotypical existences, perspectives, and identities are preferable to disabled, Mad, and neurodivergent ones. Regarding counselling and related disciplines, Thorneycroft (2020) says it like this: "Specifically, the power and hegemony of psy disciplines and discourses are imbued with the power to constitute crip and Mad bodies as fixed…universal, and ahistorical…This constitution creates psychocentrism and a whole repertoire of beliefs, practices, technologies, and discourses that work to pathologize and disorder crip and Mad bodies and lives" (p. 104). *Resistances* to this constitution include local and global access practices, reconfigured public spheres, and pathways of compliance and noncompliance (McRuer, 2006).

Contribution to the Field

There are multiple practice applications when we consider bringing Disability Justice to counselling. First, there are opportunities to expand our understanding of accessibility, which I discuss in Chapters Two and Three. Secondly, Disability Justice provides additional therapeutic tools for trauma-informed practice (Eales, 2019). Thirdly, bringing Disability Justice to the counselling field extends our understanding of cross-cultural, socially just practice. This is especially prudent, considering that a decade ago Foley-Nicpon and Lee (2012) issued a call to include disability within social justice practice in the field, and this has yet to be realized. Disability is not usually considered a core part of socially-just praxis in this field, instead often being positioned as an afterthought (Brodt, 2021). Importantly, psychologists and counsellors are uniquely positioned (especially when they are part of larger health care teams) to advocate for the elimination of ableism and to provide culturally-appropriate treatment. According to

Andrews et al. (2021), psychologists can do this in our own field *beyond* rehabilitation counselling / psychology, and we can model this for others in the caring professions, by "centering the voices of disabled people, identifying ableist practices, and advocating for Disability Justice" (p. 9). Olkin (2020) adds to this, highlighting the importance of practitioner self-examination of bias, building knowledge about disability, and strengthening cross-cultural competencies. With this research, I hope to investigate the ways in which Disability Justice could guide counsellors who wish to be in consensual solidarity with their disabled clients, who want to offer culturally-meaningful advocacy where appropriate, and who aim to sharpen their strategies for accountability and repair with disabled clients and all clients.

Reflexivity and Positionality

This study is influenced by my history, values and beliefs, my assumptions about knowledge, as well as my social location, biases and conditioning. Remaining aware of these sensibilities is of utmost importance (Efron & Ravid, 2019)**.**

My connection to this topic is a personal one. I have lived with visible disability from birth, along with invisible and chronic disability since my youth. I am more recently coming to terms with my neurodivergence and possible/proximal experiences of Madness, and so far I haven't pursued or needed a diagnosis for these. In my 20s it became clear to me that I've always been queer, and in my 30's it became clear to me that I'm nonbinary - quite a journey! I've deeply enjoyed co-organizing with queer and disabled peers on creative projects (dance, film, gardens, cooking, and others) for over ten years. In recent years I have been gladly growing my understanding of Disability Justice through those collaborations.

When I think of my reasons for bringing Disability Justice to counselling, I reflect on my own experience as a client. My most fruitful therapeutic relationships and my most timely

growth has occurred with counsellors who have an awareness of ableism and how it shows up. It is obvious to me that these counsellors have done their own work and self-reflection regarding the biases that they carry. (Unfortunately, this has been rare in my experience, and I've divorced many more counsellors than I've stayed with). In considering bringing Disability Justice to counselling, I also think about my social location as a white person with settler Irish, Scottish, and English roots, whose life is shaped by multiple privileges. I know that I need the tools to be non-harming in this world; to engage in change at multiple levels; to support clients who are racialized or who otherwise don't share my lived experience. I believe that Disability Justice is one of multiple possible pathways to build these skills and foster these relationships. I acknowledge that I am invested in the possibilities that Disability Justice can offer to all of us, since now is a time of survival for many of us (disabled and nondisabled). I believe that Disability Justice provides a map for collective thriving, and I am truthfully excited for the potential of Disability Justice in counselling.

Definition of Terms and Chapter Outline

Note to the reader: To honour the myriad ways that people self-identify, I will use a range of phrases to denote the disability experience ('disabled people,' 'people with disabilities,' 'people experiencing disability,' 'neurodivergent people,' 'Mad people,' 'crips,' etc). I situate each of these terms, when used by people with lived experience, as equally valid. Several of these terms require permission and care if used by people who do not have lived experience, or may not be used at all. Each has different lineages and multiple uses, and although interchangeability may at times be appropriate, I'll do my best to be precise and intentional in my use of each of these phrases.

Ableism functions both slowly and rapid-fire "as a core, multi-scalar dynamic of structural, social, political, institutional, interpersonal, and intrapsychic violence" (Fine, 2019, p. 973). Talila A. Lewis (Lewis, 2022, para. 3) provides this working definition of ableism:

> A system of assigning value to people's bodies and minds based on societally constructed ideas of normalcy, productivity, desirability, intelligence, excellence, and fitness. These constructed ideas are deeply rooted in eugenics, anti-Blackness, misogyny, colonialism, imperialism, and capitalism. This systemic oppression leads to people and society determining people's value based on their culture, age, language, appearance, religion, birth or living place, "health/wellness", and/or their ability to satisfactorily re/produce, "excel" and "behave." You do not have to be disabled to experience ableism.

Crip. The word "Crip" carries contradictory meanings. Historically, it has been used as a pejorative against disabled people, and more recently it's been reclaimed by disabled people to re-work old meanings and to self-identify. Crip or cripping also describes processes of resistance to, and disruption of, compulsory ablebodiedness (Kafer, 2013; Sandahl, 2003).

Disability. The meaning and experience of disability is ever-changing with context. In this study, I take disability to be an embodied experience (Morris, 1993) as well as a social, relational, political, and cultural one (Linton, 1998). Disability is still often narrowly understood as a flaw, a source of family shame, or a cultural story of tragedy (or success, once tragedy or disability are 'overcome') (Goodley et al., 2019). For decades, scholars have been examining the tension produced by these framings (which many describe as personally ill-fitting, as well as harmful more broadly) *and* the reality that disability is indeed an embodied, felt experience requiring equitable access to care (Kafer, 2013). This study lives in a 'both-and' space, where disability sometimes requires medicalized support, but is not reduced to individual pathology and is instead

understood as a nonpathological range of bodymind differences. Person-first language ("people with disabilities") and identity-first language ("disabled people") emerged independently to signify personhood and disablement due to oppression, respectively (Peers et al., 2014).

Disability Justice is described as an emergent framework, a movement which "draw[s] upon legacies of cultural and spiritual resistance…to all forms of oppression" (Sins Invalid, 2019, p. 20). There are ten guiding principles of Disability Justice , which are outlined in Chapter Two.

Mad. "The term "Mad" has been reclaimed intentionally as a deliberate interruption or sabotage of the dominant psychiatric perspective…[including] its diagnostic expertise and power." (Archibald, 2021, para. 12). Mad communities work against the pathologization of human experiences of distress, crisis, spirituality, or moral injury. These communities also advocate for equitable access to medical care if that's desired. Mad people may identify as Mad while also identifying as past or current users, or survivors, of psychiatric services. Typically, these communities prioritize mutual aid and peer support in response to distress.

Neurodivergent, a term coined in the year 2000 by Kassiane Asasumasu, means "having a mind that functions in ways which diverge significantly from the dominant societal standards of 'normal'" (Walker, 2014, section four). Neurodivergence (the state of being neurodivergent) can be largely or entirely genetic and innate (as is the case with Autism, dyslexia, or epilepsy, etc), or it can be largely or entirely produced by brain-altering experience (as is the case with trauma, physical injury and some drugs, etc) (Walker, 2014). Practitioners should be aware of self-diagnosis and medical diagnosis as equally valid experiences of neurodivergence.

Sanism describes the "ways in which society values certain forms of human consciousness and being over others - that is, the preference, expectation, and command for the sane mind (Thorneycroft, 2020, p. 96). As a result of this, people who have received diagnoses, or who are

otherwise perceived to be ‘mentally ill,’ experience systematic subjugation (Thorneycroft, 2020). Systematic subjugation can include, but is not limited to, nonconsensual pathologization as well as the denial of equitable access to medical care to those with and without diagnoses.

In Chapter Two, I review the literature on the topic of bringing Disability Justice to counselling, with subsections elaborating on firsthand client experiences of counselling, therapy effectiveness, and emerging Disability Justice approaches in counselling. Discussion and applications to clinical practice are outlined in Chapter Three.

Chapter Two: Clients' Lived Experience, Therapy Effectiveness, and Disability Justice

This literature review asks: How have neurodivergent, disabled, and Mad people experienced counselling? Has counselling in these groups been effective in supporting clients? And, what are the ways that Disability Justice may be brought to counselling? Here in chapter Two, I will provide an overview of existing knowledge on the topic of supporting disabled, neurodivergent, and Mad clients in the context of interlocking systems of power. This informs Chapter Three which provides culturally relevant, actionable recommendations to counsellors. To engage in knowledge synthesis and creation, a traditional-narrative literature review was conducted, as outlined by Efron and Ravid (2019). Findings took the form of qualitative, quantitative, or theoretical studies, and covered a range of worldviews and definitions of knowledge (Efron & Ravid, 2019). Data were gathered from across disciplines. The first section covers *clients' experiences in counselling*, including what clients considered supportive and non-supportive. The second section provides an overview of *therapy effectiveness* across disability diagnosis. In section three, I outline the ten principles of *Disability Justice* and cover existing studies integrating Disability Justice into therapeutic practice. In Chapters Two and Three, I assign more weight to firsthand accounts than is reflected in the literature as a whole. This is in order to better investigate the research question and to better reflect available sources on the topic of Disability Justice, which lean in the direction of postmodern theorizing, qualitative accounts / narratives, as well as creative, artistic endeavours and other sources of community and cultural knowledge. The lens of CDS, and subfields of crip theory and Mad studies, enable me to highlight trends, complexities, contradictions, and gaps in the counselling literature.

Clients' Experiences in Counselling

I found ten studies accounting for disabled, Mad, and neurodivergent clients' firsthand experiences of counselling. Two studies were led by authors identifying as autistic, or autistic and trans (Hallett & Kerr, 2020) and as having ADHD (Bowers & Widdowson, 2023). The overall topic of client experiences of therapy is not new in the clinical literature (Flor, 2018)**.** Client groups across social location have emphasized firsthand the importance of active listening, empathy, collaboration, and centering client autonomy in meeting client's needs (Flor, 2018). However, the perspectives of neurodivergent, disabled, and Mad clients are much less known. For example, the voices of autistic adults are "virtually silent" (Flor, 2018, p. 27) in the counselling literature, with very few authors directly asking autistic people what has or hasn't worked for them in therapy (Hallett & Kerr, 2020). There is a dearth of studies examining the experiences of those diagnosed with intellectual disability (ID) (Statham & Beail, 2018). Aside from the pioneering work of Olkin (2017), who is disabled herself, research taking into account the firsthand experiences of clients with physical disabilities or chronic illnesses is in its infancy (Conner et al., 2023). Similarly, there are few studies documenting the therapeutic experiences of clients diagnosed with psychological disability (Max, 2017). Additionally, research has largely focused on therapies which seek to address and remediate core symptoms of neurodivergence, with relatively few studies exploring the experiences of, and preferred adaptations to, general psychotherapy sought by neurodivergent people in distress (Bowers & Widdowson, 2023). Research, including qualitative investigation, which identifies disabled clients' views on the helpful and challenging aspects of psychological interventions is vital in ensuring that the client's needs are more fully met (Evans & Randle-Phillips, 2020). This is even more poignant

given disabled clients' systemic exclusion, including the limited social opportunities for some of these clients to express the happenings of their inner world.

"[The counsellor] made changes for me which have had an impact:" Client Experiences of What's Supportive

Some disabled, neurodivergent, and Mad clients reported similar themes as those of the wider literature on client perspectives. Clients across disability category and neurotype reported positive therapeutic impacts in the realms of emotional well-being, relationships, and use of new skills (Conner et al., 2023; Statham and Beail, 2018). Evans and Randle-Phillips (2020) conducted a meta-ethnography and systematic review of qualitative studies which examined the experiences of clients diagnosed with intellectual disability (ID) as they underwent adapted psychotherapeutic interventions. The authors found evidence of well-known facilitative conditions (Randle-Phillips, 2020). Clients noted the importance of a listening, empathetic, and validating stance from the therapist. Statham and Beail (2018) noted similar findings in group therapy for clients diagnosed with ID, who valued attunement when it occurred, and appreciated being able to talk about their troubles, thoughts and feelings. Hallett & Kerr (2020) suggest that counsellor warmth, care, acceptance of autistic clients, and believing the clients' experiences, are important. These moments had the effect of building trust, reducing client anxiety, and enabling the client to "ask clarifying questions, advocate for themselves, and mask [their autism] less" (Hallett & Kerr, 2020, p. 6). Autistic clients noted the importance of practitioner attunement – picking up on cues (Toor, 2019), including cues regarding a client's state of activation (Bowers & Widdowson, 2023), and giving explicit permission to unmask (Bowers & Widdowson, 2023). Clients with physical disabilities similarly noted the importance of practitioner understanding,

acceptance, and responsiveness to disability-related concerns, which amplified trust and connection with the practitioner (Conner et al., 2023).

Specifically, clients across disability group highlighted positive experiences as a result of a collaborative therapeutic relationship (Conner et al., 2023; Evans & Randle-Phillips, 2020; Statham & Beail, 2018). Max (2017) drew on CDS and used phenomenological analysis to examine the impact of ableism and sanism in counselling more broadly, and on three clients with psychological disabilities specifically. These participants' experiences in counselling largely hinged on the therapeutic alliance. Positive experiences included trust-building, authentic client input on the decisions made in the counselling room, practitioner validation and an affirming stance, and offering alternative or challenging perspectives (Max, 2017). Importantly, Toor (2019) noted that a collaborative or directive stance, a client- or counsellor-led process, were all experienced differently by autistic clients, highlighting the need for compatible client-counsellor fit.

Beneficial experiences were more likely when practitioners identified and enacted tailored, individualized adaptations. Several adaptations (for example, plain language, non-verbal techniques, visual material, role plays, and tailored homework as an aid to memory and expression of feelings) ensured a more enjoyable experience for clients diagnosed with ID (Evans & Randle-Phillips, 2020). Statham and Beail (2018) and Woolfall (2018) similarly found the use of pictures and a slower pace to increase access for this group. Woolfall (2018) found benefit in opportunities to repeat or rehearse material. Clients also expressed interest in interactive approaches with "less words and more work" (Woolfall, 2018, p. 63) and more physical practice and modelling (Woolfall, 2018). Not all neurotypes are compatible with visuals and a slow pace (as some people do not visualize at all, and some would benefit from a quicker

pace of learning). Toor (2019) suggests using visuals and homework as needed by the client, and altering pacing as needed.

On the topic of adaptations to the physical and sensory environment (including attention to light, noise and smells, seating options), or adaptations to logistics (offering multiple modes of communication, support in making appointments, attention to financial barriers) autistic clients voiced that it was important for practitioners to be open to client suggestions (Hallett & Kerr, 2020) and to make adjustments when needed (Toor, 2019). Conner et al. (2023) administered semi-structured interviews to 24 people with physical disabilities about their psychotherapy experiences, and the theme of inaccessibility was central. Participants noted high costs, inaccessible physical setting of the provider's office (including bathrooms, doors, and seating), barriers to scheduling or finding practitioners (including finding those who make allowances for disability-based cancellations), and barriers to transportation. Toor (2019) noted the value of online formats.

Autistic clients wanted to be able to ask for what they need, to express their discomfort, as well as for the counsellor to check in periodically (Hallett & Kerr, 2020). Anticipating issues and unmet needs that a client may not have thought of was also appreciated by autistic clients. Clients diagnosed with ID also note that some adaptations, considered useful by practitioners, were in fact unhelpful according to clients (Woolfall, 2018), and even with access practices in place, "counselling was not always experienced as a readily accessible service" (Toor, 2019, p. 135). Adaptations will be further elaborated in Chapter Three.

Woolfall (2018) conducted semi-structured interviews with six clients diagnosed with intellectual disability (ID) who received adapted Dialectical Behaviour Therapy (DBT). According to the authors, participants favoured behavior-based skills with explicit, concrete

instructions and visible actions. Clients diagnosed with ID also noted the benefit of having clear expectations (Evans & Randle-Phillips, 2020; Woolfall, 2018). Similarly, autistic clients spoke of the value of the counsellor explaining how counselling would work, what kind of help the counsellor could give, what is and isn't okay in sessions, what is and isn't expected, and how to use counselling sessions (Hallett & Kerr, 2020; Toor, 2019). Respondents also suggested that it would be helpful to provide this information in written form to clients. The authors state: "it's not fair to assume here that autistic clients have less of an understanding than non-autistic clients of how counselling works – autistic clients are just more likely to be 'upfront' about it, and more impacted by any uncertainty" (Hallett & Kerr, 2020, p. 6). Clients diagnosed with ID appreciated the use of focused techniques for addressing issues (Evans & Randle-Phillips, 2020), and building skills outside of sessions to improve mood and behaviour (Evans & Randle-Phillips, 2020; Statham & Beail, 2018). Similarly, physically disabled clients sought evidence of progress and personal growth, as well as gaining new perspectives and new skills for managing fears, depression, isolation, and disability symptoms (Conner et al., 2023).

Consistent with therapeutic literature generally, clients diagnosed with ID described the therapeutic process as a concurrent experience of challenge (including frustration, vulnerability, dysregulation) and reward (including enrichment, skills-development, connection, and reduced distress) (Statham & Beail, 2018). Relatedly, participants identified a mix of outcomes, including: positive changes in the areas where they'd been experiencing difficulty; no change; up-and-down nonlinear change; and a loss in previous gains (Statham & Beail, 2018). Flor (2018) conducted a quantitative survey of 87 adults with 'high-functioning autism,' in which the majority of respondents (78.2%) "agreed" or "strongly agreed" that counseling/psychotherapy was effective and 65.5% "agreed" or "strongly agreed" that counseling/psychotherapy was (or

would be) appropriate to meet their needs. However, respondents were most likely to indicate "no progress" or "not a lot of progress" (54.3%) in treatment and less likely to indicate "good" or "very good" amount of progress (28.4%). Respondents were also most likely to indicate they found their most recent treatment experience to be "slightly helpful" or "not helpful at all" (40.2%). The authors acknowledged that these seemingly contradictory patterns of responding were not well understood. Importantly, in a qualitative study regarding the experiences of ten autistic university students, Toor (2019) reported that counselling can have a positive, minimal, or negative impact, with the majority experiencing positive impact, yet more than half experiencing negative or minimal impact (including harm or damage) alongside this.

"[The counsellor] talked… about life after I get better, and the thing is that, there's no getting better:" Client Experiences of What's Unsupportive

Aspects of therapy considered unhelpful include a judgmental, presumptive, invalidating, rigid, or disrespectful stance from the therapist. Disabled clients, like all clients, noticed lapses in attunement and the impacts of those (Statham & Beail, 2018). Bowers and Widdowson (2023) conducted semi-structured interviews with six neurodivergent adults with diagnostic presentations of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), Dyslexia, Dyscalculia and Autistic Spectrum Disorder (ASD). The authors explored the use of Transactional Analysis Psychotherapy with neurodivergent clients through understanding client lived experience. This type of therapy focuses on clients' social functioning, self-efficacy, and any issues in ego states (operationalized as Parent, Adult, and Child). Interventions include working with experiences in the present, analysis of life scripts, injunctions, and counterinjunctions, as well as treatment contracts and psychoeducation (Vos &Van Rijn, 2021). Results indicated a lack of understanding from practitioners regarding the

needs of neurodivergent clients, raising the issue of relational ruptures. These occurred primarily due to assumptions and biases about neurodivergence, a focus on client behaviour and missing the underlying need, as well as practitioner's inadvertent demands on the client to mask or over-adapt in session (Bowers & Widdowson, 2023).

Counsellor reluctance to explore difficult areas was a common negative experience across disability type and neurotype (Evans & Randle-Phillips, 2020). Specifically, participants with psychological disabilities indicated that they desired, but did not experience, concrete explorations and direct naming of ableism in their counselling sessions (Max, 2017). Clients with physical disability and chronic illness highlighted the practitioner's avoidance of a participant's disability or other disability topics; inflexible, dismissive or invalidating responses (including practitioner discomfort and overwhelm); and attributing physical disability to psychopathology and dismissal of symptom severity (Conner et al., 2023).

Negative experiences for clients with psychological disabilities centered around clients' unmet needs, misunderstood intersections of identity, and feelings of being 'unaided' or 'unhelped.' (Max, 2017). For example, trans and nonbinary clients with psychological disabilities noted unhelpful heteronormativity and misunderstandings of gender identity (Max, 2017), and disabled women noted gender bias (Conner et al., 2023).

Negative experiences were also connected to practitioners' lack of knowledge of disability, disability and Mad culture, and systemic ableism and sanism. Autistic clients expressed misgivings as a result of practitioners' demonstrated lack of knowledge, outdated knowledge or approaches, and misconceptions (Hallett & Kerr, 2020). For example, practitioners relied on tropes of autistic people as emotionless, lacking empathy, and lacking in communication skills, which are still found today in journals, public health information, and

cultural representations (Hallett & Kerr, 2020). Importantly, this pattern was most noticeable in counsellors who claimed some specialist knowledge, training, or experience of autism (e.g. those who'd worked with autistic children, or who had young autistic family members). Clients were often positioned as educators on autism, as well as gender and other topics, when in fact they needed a space to explore their own learning about autism, their self-understanding and acceptance, and a possible autistic identity (Hallett & Kerr, 2020). Similarly, participants with psychiatric disabilities felt that they had to do additional emotional labour beyond what one would expect in the counselling room - partly due to the fact that counsellors failed to understand their experience and what they were feeling, in addition to the client being placed in the position of "tak[ing] care of" the counsellor (Max, 2017, p. 58).

Additionally, clients noted high levels of anxiety prior to, and during, therapy sessions. This was especially true for clients diagnosed with ID (Evans & Randle-Phillips, 2020; Statham & Beail, 2018) and autistic clients. A mixed-methods survey conducted by Hallett and Kerr (2020), which focused on 66 autistic people's experiences of talk therapies, revealed anxiety as central to the client experience. Clients held anxiety about new / prospective counselling situations as well as old ones in which the client was misread, dismissed, or where the client experienced ableist harm (e.g. explicit pressuring from counsellors to mask, or hyperfocusing on changing 'atypical' behaviours). Clients noted past experiences of counsellors not validating their experiences, being reluctant to explore implications of autistic experiences, and not normalizing their experiences in the context of broader autistic experiences (Hallett & Kerr, 2020). Clients indicated that high levels of anxiety and other feelings have gone unnoticed and unaddressed in sessions, or the cues are misinterpreted by the counsellor, or incorrectly attributed to autism itself (Hallett & Kerr, 2020). A subgroup of clients with ID did not understand why

they were in therapy, stating that therapy was different from their expectations, adding to client anxiety (Statham & Beail, 2018). Clients also reported distress at having to talk about their experiences, and struggles with maintaining changes (particularly in difficult situations), which added to their complex feelings about therapy (Woolfall, 2018).

Importantly, clients diagnosed with ID reported that they did not feel they had choice or control over many aspects of therapy, including starting therapy and decisions about therapy ending or being cancelled. Perhaps as a result of this, clients found ending therapy difficult. These clients were not always given the choice about the number of sessions and where/when they occurred, who attended therapy, and who was informed about therapeutic progress (Evans & Randle-Phillips, 2020). Notably, clients diagnosed with ID felt a reluctance to criticize or provide feedback to their therapist (Statham & Beail, 2018), indicating possible unacknowledged power dynamics. Clients additionally reported barriers to their independence throughout therapy (Woolfall, 2018), and circumstances of harm whereby clients "felt like a burden" (Statham & Beail, 2018, p. 178) as a result of being forgotten. These reports, along with important client feedback about lack of decision-making power in therapy, raise the question as to how truly accessible therapy is, even with certain adaptations in place. Evans and Randle-Phillips (2020) argue that "current adaptations to therapy are not of an acceptable level" (p. 248) and significant changes need to be made in order to meet clients' needs, including further tailoring of therapeutic process and content. The authors suggest greater support for clients in the stages of setup and preparation, clarifying expectations and answering questions (Evans & Randle-Phillips, 2020). Clients reported appreciating a private, confidential space to talk about their experiences, particularly given that privacy may not be their everyday experience given their multitude of

interactions with their support network for activities of daily living (Evans & Randle-Phillips, 2020).

Inaccessible homework was impactful for clients diagnosed with ID (Evans & Randle-Phillips, 2020) as well as other client groups. Some of these clients had difficulty applying treatment concepts outside of session, as well as difficulty in understanding or accessing mindfulness, which is a key intervention in multiple modalities (Evans & Randle-Phillips, 2020). The helpfulness of homework for autistic clients hinged on multiple factors, including individual preferences and client circumstances, potential anxiety, and the rationale for - and usefulness of - the task (Hallett & Kerr, 2020).

Lastly, therapeutic benefit hinged on broader contexts and additional supports, particularly for clients experiencing a depth of marginalization. Statham and Beail (2018) conducted interviews with 10 clients diagnosed with intellectual disability who attended psychodynamic therapies for at least four months. The authors found that clients with ID valued support to attend sessions, friendly and familiar greeting staff, and flexible, timely practitioners (Statham & Beail, 2018). The role of support staff, family, and a broader social network was important but complex in this client population. According to Evans and Randle-Phillips (2020), and Kelly (2020), clients expressed concern about what was shared with their wider network without their consent. Questions remain about how much the wider system should be involved in therapy, and how this is managed if the client does not want others included (Evans & Randle-Phillips, 2020).

Therapy Effectiveness

In the section above, findings of studies assessing therapy suggest that when *collective access* (where accessible physical spaces, materials, interventions and therapeutic processes are

prioritized, and broader support is made available when needed) and *recognizing wholeness* (seeing clients in undistorted ways) are central practices, disabled, neurodivergent, and Mad people across intersections can benefit from a variety of therapies. However this is not a guarantee, and does not preclude concurrent harm or negative experience.

In this section, studies of therapy effectiveness for disabled, Mad, and neurodivergent clients are included. Although there are inevitably diagnoses and lived experiences that are not covered here, this literature review is intentionally broad and covers multiple groups and experiences of disability. This is partly because Disability Justice is inherently intersectional and cross-community ("where no body/mind is left behind" (Berne et al., 2018, p. 229)"). A broad aerial-view also helps illustrate the similarities across groups and across interventions, while signaling differences. Note that although the following subsections are grouped according to diagnosis, there are many clients who do not have access to diagnosis, who self-diagnose, or whose lived experience doesn't fit neatly into pre-existing diagnostic categories. There are also many people who are multiply-disabled; who for example, have lived experience across realms of physical disability, neurodivergence, Madness, addiction, and more (Fullen et al., 2020). Therefore I consider the following subthemes to be loose, superficial and socially-constructed groupings, as they may not reflect the lived experience of many clients.

I include only a brief overview of therapy effectiveness for clients with psychiatric disabilities, as this client group is well-understood and the literature is vast (Benton, 2023). Additionally, there are many subgroups of 'chronic illness,' 'chronic pain,' and 'physical disability,' so a brief overview and a few select studies in these areas are included here. Similarly, there are multiple groups under the umbrella of neurodivergence (ADHD, Autism, ID, dementia, etc). I provide a brief overview for clients with ADHD, and particular attention is paid

to groups historically overlooked in therapy (e.g. clients diagnosed with ID and autistic clients) as well as groups whose experience has been delegitimized within the medical industrial complex (e.g. functional somatic syndromes). Studies that targeted core presentations of disability or neurodivergence for the purposes of remediation (e.g. social skills training for autistic adults or adults diagnosed with ID) were not included. Instead, studies which targeted therapies for mental and emotional distress or coexisting symptoms (e.g., anxiety, depression) were prioritized. All studies covered individual therapy with a single practitioner (I did not include self-study or group therapy).

Madness/Psychiatric Disability

There is extensive literature in the area of psychiatric disorder diagnoses (Benton, 2023). Research emphasizes the use of pharmacological interventions as the first choice of treatment for many of these diagnoses. Psychological interventions are a second, and often accompanying treatment for depression (Karrouri et al., 2021), PTSD (Du et al., 2022), schizophrenia-spectrum disorders (Petkari et al., 2024) and other diagnoses and comorbidities (Du et al., 2022). On the other hand, psychological interventions are considered the first choice of treatment for diagnoses such as BPD (Poloczek & Szczerba, 2024). Cognitive-behavioral therapy (CBT), including related treatments of exposure therapy and cognitive processing therapy (CPT) constitute the largest evidence base of effective treatment for depression (Karrouri et al., 2021), schizophrenia-spectrum disorders (Petkari et al., 2024) and PTSD (Du et al., 2022). Interpersonal therapy (IPT) follows as a less-researched but supported treatment for depression (Karrouri et al., 2021); EMDR holds a similar second place in PTSD treatment. Psychoeducation emerges as an important and effective modality across psychiatric conditions (Du et al., 2022; Petkari et al., 2024).

Neurodivergence

Clients Diagnosed with ADHD. Fullen et al. (2020) conducted a systematic review of a range of psychological treatments in adults with ADHD. The authors note that the majority of research has focused on the efficacy of pharmacological interventions, and that the evidence base of non-pharmacological interventions is limited, but is experiencing a recent upsurge. The authors also noted some limits in the literature, including an emphasis on RCT's, a focus on CBT and group therapy design, small sample sizes and other methodological weaknesses, as well as the nascent state of the literature overall (Fullen et al., 2020). Therapies with the largest evidence base included CBT, closely followed by mindfulness-based approaches and DBT, with neurofeedback and other approaches being less researched. Across studies, outcome measures on core symptoms (inattention, hyperactivity/impulsivity) and secondary symptoms (anxiety, depression, rumination) as well as global self-esteem and quality of life measures, suggests efficaciousness of CBT interventions (Liu et al., 2023; Fullen et al., 2020). Lopez et al. (2018) highlight low quality evidence which suggests CBT treatments may be of benefit in the short term only. The positive effect of mindfulness-based interventions have been reported by multiple authors (Bachmann et al., 2018; Mitchell et al., 2017), supporting its clinical use with clients diagnosed with ADHD, and DBT is considered potentially useful given the current state of evidence, though more research is needed (Fullen et al., 2020).

Autistic Clients. According to Flor (2018), treatment approaches such as such as cognitive-behavioral therapy (CBT), social cognition training, and acceptance and commitment therapy (ACT) are found to be effective when working with autistic children and adolescents, and these results may be extrapolated to adults (Flor, 2018). However, without data from outcome studies or trials, little is known about the effectiveness of these therapies in adults

(Anderberg et al., 2017; Flor, 2018). In the literature that exists, there is a relative lacuna regarding some therapies in particular. For example, systemic therapy (which focuses on "problems as developing in the space between people" (Haydon-Laurelut, 2016, p. 2) has been rarely conducted with autistic clients, ostensibly as a direct result of the individualization and pathologization of autism in the global North (Haydon-Laurelut, 2016). Additionally, existing studies are known for racist bias and the underrepresentation of racialized autistic people (Jones et al., 2020). In general, studies are of weaker quality due to small and biased samples normed on dominant groups, as well as lack of randomization and control conditions (Schweizer et al., 2024). As a result, few evidence-based tailored options exist for autistic adults (Schweizer et al., 2024).

Cognitive-behavioral therapy and mindfulness-based therapies are among the most widely considered mental health interventions with autistic adults (Mazurek et al., 2023; Pahnke et al., 2019) with CBT showing efficacy in treating anxiety and other comorbid conditions (Anderberg et al., 2017; Schweizer et al., 2024). A related therapy, ACT, provided in individual and group settings, shows mixed results but some promise in reducing distress (Byrne & O'Mahony, 2020; Pahnke et al., 2019). Despite initial investigations, further adaptations are likely needed (Byrne & O'Mahony, 2020; Pahnke et al., 2019), and the relative effectiveness and feasibility of specific mental health strategies among autistic adults has not been previously examined (Mazurek et al., 2023), including for those with comorbid conditions **(**Pahnke et al., 2019). Other therapies, such as EMDR (Van Diest et al., 2022), are increasingly being considered when working with autistic clients; however, there is no consensus about which adaptations may be important, or why and how they are incorporated into EMDR therapy (Van Diest et al., 2022).

In a study conducted in a college counseling setting, Anderberg et al. (2017) collated outcome questionnaire data for 56 students who were retrospectively identified as autistic and 91 students who were possibly autistic but without a formal diagnosis. Therapies included CBT, person-centered, emotion-focused, and ACT. Autistic clients were shown to have similar levels of distress as their neurotypical peers, and to improve about the same amount from pre- to post-treatment. However, autistic students stayed in treatment for significantly more sessions than neurotypical clients, took significantly longer to achieve improvement on outcome measures, and experienced significantly higher deterioration at at least one point across sessions.

Sizoo and Kuiper (2017) investigated the relative effectiveness of two treatments - Mindfulness Based Stress Reduction (MBSR) and (CBT) - in reducing anxiety and depression in 32 and 27 autistic adults, respectively. Measures of anxiety, depression, rumination, global mood, and 'autism symptoms' were administered at treatment start, at treatment end (13 weeks) and at 3-months follow-up. A reduction in anxiety, depressive symptoms, ruminations, and 'autistic symptoms' was seen in both MBSR and CBT treatment groups, and changes persisted at follow up. The authors indicate some evidence that MBSR reduces anxiety to a greater degree than CBT, especially if irrational beliefs are high at baseline, and might be a preferred therapy. Gaigg et al. (2020) conducted a pilot randomized controlled trial examining CBT and mindfulness-based therapy in an online format. The authors found significant reductions in anxiety at treatment baseline, end, and follow up, drawing similar conclusions.

Clients Diagnosed with Intellectual Disability. Despite significant need, and despite potential cultural shifts toward the "acceptance, albeit limited" (Shepherd & Beail, 2017, p. 95) of the provision of therapy to clients diagnosed with intellectual disability (ID), there is a lack of robust empirical evidence regarding the effectiveness of psychological interventions in this

group (Patterson, 2019; Woolfall, 2018). This could be, in part, because of an emphasis on skills training, behavioural management and medication as opposed to psychological intervention (Cooper & Frearson, 2017). Clarke (2020) and Patterson (2019) note that existing studies of CBT therapies, as well as psychodynamic therapy and third-wave therapies, tentatively suggest therapeutic benefit for clients diagnosed with ID. Preliminary findings in recent years have shown promise for the use of adapted Cognitive Behavioural Therapy (CBT) which currently constitutes the largest evidence base for this group (Clarke, 2020; Jahoda et al., 2017; Patterson, 2019; Shepherd & Beail, 2017; Woolfall, 2018). Importantly, Jahoda et al. (2017) note that adapted-CBT is not a "dumbed-down version [but uses] precisely the same fundamentals as contained in established models of CBT" (p. vi). Adapted CBT relies on an imaginative and client-centered stance. Adaptations include but aren't limited to: using storyboards; finding alternative means for client self-monitoring (including thought records and diaries completed with the help of a support person, or using audio instead of written formats); introducing tasks slowly and in small steps to ensure shared understanding; including materials with accessible language and layout; and practicing tasks experientially in sessions themselves before assigning homework (Jahoda et al., 2017).

Psychodynamic and psychoanalytic therapies have shown mixed evidence for effectiveness in this group (Clarke, 2020; Woolfall, 2018; Shepherd & Beail, 2017). Some positive therapeutic outcomes for clients include high levels of satisfaction with therapy, improvements in self-esteem, and improvements in relationships (Shepherd & Beail, 2017). Authors also note variability in findings, gender bias, poor quality research in this area and the need for larger scale, controlled studies (Shepherd & Beail, 2017). Skelly et al. (2018) conducted a systematic open trial of psychodynamic therapy offered to 30 people diagnosed with mild and

moderate ID, who presented with significant emotional distress. Clients attended an average of 22 sessions, though the number of sessions varied. Self-report and independent ratings indicated that clients' emotional distress improved significantly during therapy and were maintained at a six-month follow-up. The authors noted that psychodynamic work is possible for this population, despite the widely-held assumption that people diagnosed with ID do not have insight to tolerate the process (Skelly et al., 2018).

Third-wave therapies, such as solution-focused therapy (Cooper & Frearson, 2017) ACT, DBT (Patterson et al., 2020), and compassion-focused therapy (CFT) are also capturing researchers' interest for this client group, particularly when CBT is incompatible with the clients' needs (Cooper & Frearson, 2017). Evidence indicates improved mental health symptoms, shifts in behaviour, and improvement in mindfulness/acceptance skills for some clients receiving third-wave therapies (Patterson, 2019).

As part of the third wave, recent research includes case studies demonstrating the effectiveness of mindfulness-based approaches in this group. In one case study, a client with dual diagnoses of learning disability and a personality disorder received adapted-DBT in both individual and group formats (Ashworth et al., 2017). Findings showed mixed effectiveness – an increase in use of mindfulness techniques and adaptive coping strategies, but no overall reduction of emotional and psychological distress, including self harm (Ashworth et al., 2017). Adaptations included the use of outside supports to complete homework, practitioner modelling of skills and making space to rehearse skills in session, using supported role-play, individualized explanations and examples of skills, and establishing a shared DBT language, among others (Ashworth et al., 2017). Adapted DBT therapies are also delivered in group-only settings for clients diagnosed with ID (Crossland et al., 2017). Multiple authors are investigating

Compassion Focused Therapy (CFT) in this client population (Cai & Brown, 2021), in both individual (Cooper & Frearson, 2017; Hardiman et al., 2018) and group (Clapton et al., 2017) formats. In a case study with one client diagnosed with ID, who also experienced low mood, adapted-CFT was used across 13 sessions (Cooper & Frearson, 2017). Adaptations included: use of colourful visuals in sessions and in homework as prompts; repetition of verbal summaries; asking the client to summarize to check his understanding; slower pace in sessions, with reduced content; and accessible language around CFT concepts (Cooper & Frearson, 2017). The case study design, which incorporated client feedback, indicated mixed results. Outcome measures completed by the client showed a lack of change as a result of the therapy, yet the client provided positive feedback about the overall experience. The authors noted systemic barriers and lack of support outside of sessions which may have been disruptive to client progress, and point to the potential for meaningful adaptation of CFT in this client group (Cooper & Frearson, 2017). Hardiman et al. (2018) conducted a mixed-methods study assessing the effects of CFT on anxiety levels of three adults diagnosed with ID. Through questionnaires on topics of anxiety and self-compassion, and recorded interviews, the authors found a decrease in client anxiety (although anxiety remained at clinical levels), improved compassionate attitudes, increased sense of common humanity (though clients still experienced isolation and chronic unsafety with others), and clients' use of mindful distraction techniques (Hardiman et al., 2018).

Authors argue caution in interpreting results in this population, as studies are found to be poor quality (Patterson, 2019) and systematic reviews are correspondingly poor in quality (Clarke, 2020). No conclusions can be drawn about which therapeutic modality works best for clients diagnosed with ID (Clarke, 2020), and authors note the need for future research to build on the current evidence-base, using rigorous designs and standardized measures (Kelly, 2020).

Kelly (2020) additionally suggests a focus on the process of therapy, including communication barriers faced by clients with ID.

Functional Syndromes, Chronic Illness & Physical Disability

Functional Somatic Disorders (FSDs) include irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome, and other conditions of persistent pain, fatigue, or functional organ disturbance, as well as functional neurological syndromes (Krivzov et al., 2021). Functional somatic disorders have been delegitimized and contested for decades, but are increasingly recognized due to patient advocacy and intersectional analysis (Violet, 2022). A recent definition positions FSDs as an umbrella term that includes persistent and troublesome physical symptoms, and resultant impairment or disability (Krivzov et al., 2021). Collectively, these reflect the complex interplay of biological, psychosocial factors and body-brain functions and dysfunctions (Abbass et al., 2021) as well as genetic factors, central sensitization, habituation, trauma, interpersonal dynamics (Krivzov et al., 2021) and cyclical inflammation (Carvalho et al., 2022) . The most commonly studied psychological approaches for FSD are CBT and its derivatives. Meta-analytic reviews of these interventions reveal varying but often small effects (Abbass et al., 2021). According to a review conducted by Abbass et al. (2021) on within-treatment effects of psychodynamic psychotherapy for this population, results show significant improvement of somatic symptoms, and to a lesser extent anxiety, depression, and interpersonal problems, during the course of treatment. Effects were larger for clients with chronic pain or gastrointestinal conditions than for functional neurological disorders.

In recent years, there has been a healthy proliferation of treatment outcome studies for functional neurological disorders (FNDs) and comorbid mental-emotional distress (Myers et al., 2021). Psychotherapy approaches that have been utilized for FND include CBT and exposure

therapy, third wave approaches (like ACT) and psychodynamic psychotherapies in individual and group settings. Significant overlaps / universal elements across therapies include psychoeducation, specific tools (e.g. relaxation, grounding, or distracting techniques), recommendations (e.g. self care), and definitions of success (e.g. understanding of triggers and tracking emotional dysregulation, shifting behaviour patterns) (Myers et al., 2021).

Krivzov et al. (2021) conducted a metasynthesis of 23 published case studies of people with Functional Somatic Syndromes (FSS) who received psychotherapeutic treatment from multiple orientations. Results indicated that clients experienced frustration, and often perceived others (including counselling practitioners and medical practitioners) as unreliable, unavailable, overcontrolling, and overprotective (Krivzov et al., 2021). Clients regularly detailed past circumstances of abandonment, trauma, or abuse concurrent with FSS diagnosis. According to the authors, psychotherapists report considerable communication and relational difficulties (including over- or under-compliance in session and adverse transference/countertransference reactions) resulting in mutual mistrust and premature termination. Further, "practitioners perceive these patients as 'difficult to treat' and often feel overburdened and stuck" (Krivzov et al., 2021, p. 594). The dominant evidence-based approach for treating FSS is CBT, though it is shown to be less effective in treating FSS than other conditions, indicating that it fails to target relevant mechanisms (Erkic et al., 2018). Krivzov et al. (2021) argue that this reveals the need to shift from a focus on perception and cognitive processes to interpersonal factors, including interpersonal dynamics and attachment, and their implications for the therapeutic relationship. The authors note the significance of the practitioner's relational strategy of being a different (reliable) other to the client, facilitating acceptance and nourishing the therapeutic alliance,

suggesting that Interactional pattern analysis (IPA) or other systemic approaches could be of use (Krivzov et al., 2021).

Multiple authors have studied the use of third wave therapies for clients with chronic illness and/or chronic pain. These have been noted for their usefulness to clients who do not respond to other therapies (Knowlton et al., 2019) or when therapies such as CBT have limited effects (Hughes et al., 2017)**.** Conditions include some of those named above (e.g. fibromyalgia, irritable bowel syndrome), with the addition of diabetes, skin conditions, all cancers, Crohn's, lupus, HIV-positive status (Benton, 2023), and more (Carvalho et al., 2022). Evidence supports the use of ACT (Carvalho et al., 2022; Knowlton et al., 2019**;** Feliu-Soler et al., 2018) and CFT (Carvalho et al., 2022) in these groups. These therapies highlight the potential of shifting from a stance of wanting to extinguish intractable symptoms towards a stance of "willingness to re-engage in a valued life while continuing to live with [chronic illness]" (Knowlton et al., 2019, p. 254). Knowlton et al. (2019) conducted a single-case study on the use of ACT with a client presenting with chronic pain and comorbid depression. Outcomes were measured across areas of client symptoms, therapeutic processes, and client psychological flexibility surrounding chronic pain, and patient self-reports were included. Results indicate notable improvement across areas of psychological flexibility, depression, and flexibility in enduring illness-related pain, and in client self-reported improvements in quality of life overall. A randomized controlled trial conducted by Carvalho et al. (2022) assessed the acceptability of, and compared the efficacy of, ACT and CFT – both conducted online and across four sessions with 25 and 24 clients, respectively. Results showed both interventions were deemed acceptable, with high satisfaction ratings from clients and attrition rates comparable to those found in similar studies. Additionally, participants presented with less uncompassionate self-responding, less illness-related shame, and

more valued living after the intervention, although not at clinically significant levels. There was little difference between the two therapies, with results sustained at a six month follow up (Carvalho et al., 2022).

Studies have found mixed results as to the effectiveness of psychosocial interventions on the wellbeing of clients experiencing physical disability, though a rapidly evolving literature supports the efficacy of ACT-based treatment protocols (Zemestani & Mozaffari, 2020). Zemestani and Mozaffari (2020) conducted a randomized controlled trial to evaluate the effectiveness of acceptance and commitment therapy (ACT) on depressive symptoms in a sample of 52 people diagnosed with limb 'deficiency,' muscular dystrophy, cerebral palsy, spinal cord injury, or spina bifida. After eight weeks, significant changes in depressive symptoms were observed in the group receiving ACT therapy compared to the control group, which received psychoeducation regarding depression. The authors conclude that ACT significantly reduced the participants' symptoms of depression, targeting psychological flexibility, emotion regulation, and overall psychological well-being. Other third wave therapies such as gestalt and movement-based therapy (Soraka, et al., 2021) have been shown to have promise in clients with physical disabilities.

Concluding Remarks

This literature review reveals commonalities across client groups. First, there is a predominance of CBT therapies for all disabled, Mad, and neurodivergent client groups. This is not surprising given the dominance of CBT in the literature generally, although multiple authors speculate that CBT is not universally suitable for all groups. Second, authors observe commonalities across therapeutic modalities (the importance of the therapeutic alliance, the usefulness of psychoeducation, similar definitions of success across modalities, the importance

of tailored approaches compatible with each client's characteristics, etc). This suggests that common factors (Gehart, 2018) are an important yet under-studied aspect of practice with disabled, Mad, and neurodivergent client groups. Third, though there are trends, there are also mixed results and a lack of consensus in the literature about which interventions are most effective in these groups, and why. Fourth, the need for more research and attention to these clients has been clearly indicated.

It's worth noting that multiple authors call for further research, particularly Randomized Control Trials (RCT)'s and other standardized designs (Schweizer et al., 2024). Cognitive Behavioural Therapy, as a manualized therapy, fits easily within these research designs, and I acknowledge, like Benton (2023) the strengths of RCTs, primarily in their statistical power and in the production of strong evidence for correlational or causational relationships. However I take my cue from Benton (2023) who also calls for …. "researchers to venture beyond this model in favor of other research methods, designs, and psychotherapy orientations that would provide more attention to the lived experiences of PWD [people with disabilities]." (Benton, 2023, p. 54)

Disability Justice

Disability Justice is described as an emergent framework, a movement which "draw[s] upon legacies of cultural and spiritual resistance…to all forms of oppression" (Sins Invalid, 2019, p. 20) as well as "a vision and a practice of what is yet-to-be, [and] a map that we create with our ancestors and our great-grandchildren onward" (Sins Invalid, 2019, p. 26). Disability Justice practices are widely acknowledged as emerging from conversations between disabled people of colour circa 2005, specifically Patty Berne, Mia Mingus, and Stacey Milbern, and others from Sins Invalid and elsewhere in the Bay Area (Sins Invalid, 2019). Disability Justice is

now mobilized around the globe by autonomous grassroots groups, primarily led by disabled people of colour, and queer and trans disabled people. Disability Justice is a movement to create equity for all people - to work toward collective liberation - which centers the lived experiences of multiply-marginalized disabled people (Brodt, 2021). This movement uproots ableism, benefitting both disabled and nondisabled people in real and material ways. Disability Justice is also a response to the gaps in the disability rights movement of the Global North, which include: its single-identity focus; leadership from white people without due consideration of white supremacy culture; and the dominance of people with mobility impairments which has reinforced the disability hierarchy (Sins Invalid, 2019). Disability Justice is a paradigm shift from promoting independence and hierarchy to interdependence, collectivism, solidarity across disability and neurotype, and solidarity with other social justice movements (Andrews et al., 2019).

There are ten principles of Disability Justice put forward by Sins Invalid (2019). For added simplicity, I have loosely assigned these ten principles (each principle *italicized*) to three groups (each group **bolded**): **assumptions about humanity**, **frameworks**, and **practices for justice-doing**. The first **assumption about humanity** is that people are inherently whole, and have worth (*recognizing wholeness*). Second, we are tied to each other, to all living systems and to the land (our *interdependence*), such that the liberation of these living systems is integral to the liberation of our human communities. The third principle (and a **framework**), is *intersectionality* (Crenshaw, 1989) which helps us to understand people's lived experiences, and embraces the nuance and complexity of a person's co-existing privilege and oppression. Additionally, *anti-capitalist politics* helps us to disentangle our worth from how much we can produce, requiring us to resist wealth accumulation, competition, normative modes of labor, and

the invisibilization of disabled people's labour. **Justice-doing practices** include ensuring the *leadership of those most impacted* (in this case, disabled people of color and queer and gender nonconforming disabled people). This assists us in staying grounded in real-world issues and creative strategies to navigate them. Justice work across social and cultural movements, across the globe, and across issues *(cross-movement solidarity)* requires a meaningful engagement with racial, environmental, and reproductive justice, queer, trans, and fat liberation, Deaf activism, prison abolition, and more. Working across disability experience or labels *(cross-disability solidarity)* is also key. Practicing *sustainability* means that we pace ourselves, we understand our bodies and experiences as critical reference points, and we shift away from urgency. Ensuring *collective access* requires that we go beyond norms of able-bodiedness and neurotypicality, and that we share responsibility for our access needs. We can resolve conflicting needs with compassion, "flexibility and creative nuance"(Sins Invalid, 2019, p. 26). Lastly, *collective liberation* allows us to honour our inheritances and our futures, to be together, to work and move together, in a way that leaves no bodymind behind.

I found three peer-reviewed articles which bring Disability Justice directly to therapeutic practice, suggesting that research and practice in this area is in its infancy. Similar topics such as disability cultural competency (which is also still in its infancy), as well as social justice and intersectionality more broadly, are not included as part of this literature review but are addressed more fully in Chapter Three.

Andrews et al. (2019) wrote a commentary responding to the removal of the word 'disability' from the Disability Resource Room (the hub for accommodations) at the 2018 American Psychological Association (APA) Annual National Convention. The authors, who are themselves disabled, issue a call to practitioners to intentionally use the words 'disability' and

‘disabled.’ More broadly, they highlight the dangers of disability erasure through language, policy change, and systemic disavowal. They point to the importance of disability culture, and the protection of disabled people through implementing Disability Justice in the psychology and counselling fields.

Brodt (2023) meditates on three ways to bring Disability Justice to counselling practice. First, we can implement practices of “persistent access” (Brodt, 2021, p. 9), across multiple domains, in ways that benefit us all. Persistent, collective access practices are more fully elaborated on in Chapter Three. Secondly, recognizing our interdependence is key to bringing Disability Justice to therapeutic practice. Brodt (2023) recognizes that interdependence can be challenging for practitioners, who, like everyone, are conditioned by ableist biases and cultural scripts of independence. An authentic integration of interdependence requires a closer look at deeply-held views which impact our ability to work with clients who have less power (Olkin, 2017) or clients who may be positioned as ‘dependent.’ As Brodt (2023) puts it, “to fully recognize our interdependence, we need to remind ourselves that we are simply humans working with another human towards mutual goals. In therapy, this might be moving towards a life that fits the client’s values” (p. 6).

Third, Brodt (2023) suggests that we redefine resilience as a way to more fully integrate Disability Justice into therapeutic practice. The author calls on us to shift away from individualized understandings of resilience, which are argued to: rely on normative expectations of functioning; ignore systemic barriers to thriving; and perpetuate unrealistic (and ableist) portrayals of inspirational disability (Brodt, 2023). A social constructivist, relational approach to resilience supports us in more fully accounting for access to resources (Runswick-Cole & Goodley, 2013), while liberation psychology, disability activism, and transformative justice

situate resilience as a quality of the collective – a reflection of community wholeness, care, creative resistance, and generative responses to harm (Brodt, 2023).

In a third study, Sayre (2022) brings together queer performance theory and Disability Justice to explore the role of creative arts therapies, specifically drama therapy, in meeting the emerging needs of marginalized populations. Through autoethnography, the author delineates the limitations of medical, individualized models of mental health and health care. The author proposes alternative approaches to providing care, rooted in mutual aid, community organizing and creative pursuits (Sayre, 2022).

Chapter Summary

This literature review explored *clients' experiences in counselling*, revealing what clients considered supportive and non-supportive, and highlighting the reality of concurrent harm and benefit in the counselling room. An overview of *therapy effectiveness* revealed common themes across disability diagnosis, including an emphasis on CBT therapies and evidence of its efficacy (with adaptations), as well as evidence for the use of other therapies, and the need for further study. In section three, the creative possibilities of integrating *Disability Justice* into practice was explored. In the next chapter, I cover practical recommendations, including disability-cultural competencies and disability-affirming practice.

Chapter Three: Discussion, Recommendations, Conclusions

Findings from the literature review indicate the need for practitioners to: examine ourselves and our frameworks more clearly; understand our disabled, Mad, neurodivergent clients in context; attend to the therapeutic relationship; and build a repertoire of effective, accessible clinical interventions. This chapter contains discussion and recommendations for practice in four sections. In the first section, *The Frame*, I outline disability-affirming case conceptualization informed by existing literature and by the Disability Justice principles of *intersectionality, anticapitalism,* and *interdependence.* In section two *Working from Within*, I elaborate on the need to counter internalized distortions and ableist bias, informed by literature and by the Disability Justice principle *recognizing wholeness*. In section three *Working Relationally,* I discuss trauma-informed practice and a disability-affirming therapeutic alliance informed by literature. Section four, *Working Cross-Culturally,* provides insights on culturally-responsive practice with disabled, Mad, and neurodivergent clients, informed by literature and by the Disability Justice principle *leadership of those most impacted.* Section Five consists of practice recommendations entirely devoted to the Disability Justice principle of *Collective Access.*

The Frame: Disability-Affirming Case Conceptualization

Benton (2023) cites frequent errors in practitioner's case conceptualizations when working with disabled clients, highlighting the need to start at this stage before contemplating interventions. Olkin (2020), who is herself disabled, has pioneered work in this area. The author offers us important foundational practices in what she calls *disability-affirmative therapy,* which follows the biopsychosocial model of disability (Olkin, 2017), with emphasis on the social model (Max, 2017). Disability-affirmative therapy is not a treatment or an intervention, but refers to "a

method of collecting and systematizing information regarding a client's current disability status, beliefs, values, and problems" (Olkin, 2020, p. 1). Case conceptualization with disabled clients serves as a template for understanding a client's experience in a wider context, including a client's history, as well as their social, cultural, and structural context. Additionally, case conceptualization signals the client's relationship to disability itself, as well as how the client might relate to the practitioner and others.

There are nine areas of consideration as outlined by Olkin (2020) : (a) current disability status, including pain and fatigue; (b) client history across medical, educational, developmental, and other domains, including disability/illness experiences and beliefs over time; (c) client's current models of conceptualizing disability; (d) client's social context and intersectionality of identities; (e) relationship to disability culture and community, if any; (f) experiences and management of discrimination and microaggressions; (g) effects of disability status on friendship and social interactions; (h) emotion regulation; and (i) disability effects on family, intimate relationships, and sexuality. A disability affirmative case conceptualization places the disability experience in a balanced and non-pathologizing context, "without overemphasizing or underestimating its role in the person's current presenting [concerns]" (Olkin, 2020, p. 2). This balanced positioning then allows for appropriate interventions. Importantly, a practitioner's case conceptualization must be consistent with the client's own understanding of disability in order for therapy to be of benefit (Hallett & Kerr, 2020; Max, 2017; Olkin, 2020). If a client comes to therapy with desires for their disability to be 'fixed,' then this itself becomes a site of relational exploration, deconstruction, and self-reflection for the Disability Justice-oriented therapist (Sayre, 2022).

According to Olkin (2020), the first steps toward effective treatment with disabled clients involve the practitioner's self-examination of biases and beliefs (discussed in the next section), as well as acquiring specific knowledge about disability, followed by training in disability-related cultural competencies (also discussed later in this chapter) (Olkin, 2020). Conner et al. (2023) additionally suggests that practitioners be aware of minority stress theory "and consider its use in case conceptualizations to better understand the social, cultural, and contextual factors contributing to disabled clients' distress and dysfunction" (p. 997). More specifically, multiple disabled and neurodivergent authors point to the importance of the practitioner's ability to recognize and name ableism (Hallett & Kerr, 2020; Olkin, 2017;) and, going further, for their therapy approaches to be actively anti-ableist (Max, 2017). Disability-affirming therapy makes room for the client to share about (and be witnessed in) their experiences of ableism, including everyday microaggressions. This framing paves the way to work with the client to "counter the pervasive experiences of ableism and minimize internalized ableism" (Olkin, 2020, p. 2). Ableism involves layered impacts on disabled people themselves as well as on their caregivers. It shows up as "external and internal conflicts" (Benton, 2023, p. 17) and ableist expectations, leading to mixed, complex feelings for many disabled people. These can include feelings of "inferiority, dependence, exclusion, and loss" and other manifestations of internalized ableism (Benton, 2023, p.18). Navigating ableism can be emotionally, mentally, and physically draining for disabled people, "[leading them to] question their abilities, their realities, or their decisions" and to rely on survival mechanisms of appeasing others (Max, 2017, p.58). Disability-affirming and minority-stress approaches to case conceptualization can support clients in recognizing ableism, and coping with and mitigating its effects, which eventually promotes healing.

While this mode of case conceptualization requires asking direct questions about disability, it's worth noting that some disabled clients might avoid the topic of disability. Clinical judgment is important in this case, as we strike a balance between meeting clients where they are at (including cultivating a non-intrusive line of inquiry that remains relevant to the client) and ensuring that we do not omit any aspect of a disabled client's personhood (including providing entry points to the topic of disability). As Benton (2023) phrases it: "mental health professionals must … have the tools to appropriately address the disability-specific issues that can arise, as well as the sophistication to not focus solely on a person's disability if another concern is the presenting problem. While some disability narratives involve adjustment and loss, some involve pride" (p. 18). Conner et al. (2023) suggests asking clients directly about whether to center disability-related topics in session.

Intersectionality, Anticapitalism and Interdependence

Principles of Disability Justice can fruitfully inform our case conceptualizations. *Intersectionality* (Crenshaw, 1989) helps us to understand people's lived experiences more fully, including a person's co-existing privilege, oppression, and possible internalized oppressions. Olkin (2020) notes that most peer-reviewed studies on the topic of supporting disabled clients in therapy are "devoid of intersectionality" (p. 3), lacking information on gender, sexual orientation, sexuality, religion, abuse history and substance use history (Olkin, 2020). Drawing from clients' own recommendations, Conner et al. (2023) suggests paying specific attention to disability subpopulations as part of an intersectional approach, such as men, 2SLGBTQ+ disabled people, and disabled people of colour. Additionally, Max (2017) highlights the fact that many clients live at the intersections of multiple types of disability, noting that the 'hierarchy of impairments' and the historic division of disabled people into impairment groups is an approach

that “distinctly lacks intersectionality” (Max, 2017, p. 57). Intersectionality supports us in understanding the nuances of client’s lived experience and social location. We can illuminate the increased burden felt by clients at particular intersections (Max, 2017) without conflating differences. For example, Hallett and Kerr (2020) found that autistic clients wanted counsellors who understood the intersections of autism and other co-occurring conditions (e.g. anxiety or PTSD) without dismissing their distress or conflating their distress with autistic traits. Importantly, intersectionality also reveals points of opportunity, as explained by Holley et al. (2012, as cited in Max 2017): “social locations are critical areas of emphasis, with recognition that multiple group memberships [...] lead to different experiences with privilege, oppression, and opportunities for resistance related to one’s perceived mental health status” (p.1058). Leaning into an intersectional framework is more than just an intellectual exercise. Hallett and Kerr (2020) show that starting with some “basic reference points with regards to neurodiversity, gender, and LGBT+ issues [helps us to] reach a more positive, productive and collaborative therapeutic alliance” (p. 21). In this way, an intersectional approach has the potential to decrease the emotional labour imposed on many disabled clients who are often put in the position of educating counsellors about their identities.

In addition to intersectionality, it is important to integrate two other principles of Disability Justice into our case conceptualization. *Anti-capitalist politics* supports us in separating our clients’ worth from their productivity or job status. In practical terms, this means: 1) acknowledging the range of disabled people’s labour (both paid and unpaid), as well as the reality that for many disabled people, getting basic needs met can consume the majority of their time and energy (Benton, 2023); 2) acknowledging the ways that workplaces are often inaccessible or laden with barriers; 3) understanding that being unemployed or underemployed is

often traumatizing to disabled clients; 4) knowing that not everyone is eligible for income assistance, and, for many of those who receive it, government assistance so constraining so as to be a form of legislated poverty.

Including *interdependence* in our case conceptualizations has multiple practical implications for supporting disabled clients. First, questioning hegemonic notions of independence is crucial to the way we see our clients. This is not to bypass the reality of disabled people's access needs or their need for support, but to highlight the ways that disabled people are positioned as dependent, such that their access needs are distorted into *structured dependencies* (Kelly & Chapman, 2015). Second, disabled people have been writing, thinking, and creating on the topic of interdependence for decades. This cultural work brings light to the fact of inherent interdependence in our everyday interactions (Mingus, 2017), and to the need for networks of mutual aid amongst community members, disabled and nondisabled (Spade, 2020). For example, these survival networks intensified at the onset of the pandemic (Piepzna-Samarasinha, 2019) and are ongoing as the pandemic persists. The realization of our interdependence assists us in establishing reciprocal relationships and prioritizing the needs of all, and in knowing that the liberation of living systems is integral to the liberation of our human communities. Understanding interdependence in this way is a natural fit with therapeutic practice, deriving from and building upon lineages psychology of liberation (Singh, 2020). With a disability-affirming case conceptualization in mind (further informed by lenses of intersectionality, anticapitalism and interdependence), in the next sections I cover internal, relational, and cross-cultural practices, as well as collective access practices of benefit to practitioners.

Working From Within: Recognizing Client Wholeness, Countering Distortions and Other Ableist Bias

In this section, I touch on the ways in which practitioners can *work from within*. The third principle of Disability Justice, *recognizing wholeness* (such that disabled people, and all people, are understood as inherently whole and inherently having worth) is integral to this inward work. Recognizing client wholeness may seem obvious; however, ableist bias is often strongly-held by practitioners (American Psychological Association, 2022), resulting in distortions and false assumptions (Olkin, 2020). Therefore, as part of recognizing disabled, neurodivergent, and Mad clients' wholeness, as well as the wholeness of all of our clients, practitioners are tasked with an honest accounting of their own internalized ableism in its myriad forms. We need to not only see disability as a "naturally occurring part of the human experience" (Conner, 2023, p. 997) but to see ableism as unnatural – not inevitable, but changeable. Indeed, the fields of counselling and psychotherapy are "later than other disciplines to see [people with disabilities] as multi-faceted… the need to rectify this error is imperative, given the prevalence of disability" (Benton, 2023 p. 19). In other words, practitioners must recognize the ways in which we hold distorted views of disabled, Mad, neurodivergent clients, and to actively grow non-distorted, balanced understandings of these clients.

In one example of this, Olkin (2020) notes that disability is often viewed as the defining characteristic of a person, resulting in a flattening of other important aspects of identity and lived experience. Relatedly, the spread effect (Wright 1983, as cited in Olkin, 2020) describes the process of all aspects of the individual being viewed as related to or caused by their disability. Additionally, recognizing internalized ableism involves the "need for counsellors to resist or challenge their own and society's ideas around normalization and typicality" (Hallett & Kerr,

2020, p. 17), and to question specific misinformation and unconscious stereotypes related to disability. Studies show that mental health practitioners treating people with psychiatric disabilities "hold prejudicial attitudes towards individuals with certain types of impairments (schizophrenia, substance abuse disorders) and towards clients whose symptoms are rated as more severe" (Max, 2017, p. 13). Neurodivergent clients (Hallett & Kerr, 2020) as well as clients diagnosed with intellectual disability (Patterson, 2019) and clients with physical disability (Conner et al., 2023) have all encountered misinformation and practitioner bias in session. In the counselling room, ableism can take the form of: delegitimizing the client's experience of disability; avoiding the topic of disability or diagnosis (without directly challenging the stigma related to diagnosis); assumptions about client's work life or relationship to work; assumptions about competency or experience; negative judgments about energy levels, pacing, resting, and the time needed to complete tasks (coded as 'laziness') (Bowers & Widdowson, 2023); or assumptions about sexuality. Max (2017), also observes that practitioners may withhold compassion from clients seen as 'difficult' or clients with conditions seen as untreatable (such as personality disorders) or self-inflicted (such as eating disorders). Similar judgments and withholding of compassion might occur with clients whose disability resulted from reckless or careless behavior (Andrews, 2019), all of which has direct implications for the therapeutic relationship. Additionally, practitioners may be grappling with their own personal fears and anxieties regarding mortality, aging, or embodied vulnerability (Andrews, 2019), which is important fodder for self-reflection and perhaps consultation/supervision. In this vein, some practitioners attempt to provide cures or quick-fixes, or they overly-sympathize, cry, or are "overly positive rather than helping to realistically manage disability-related distress" (Conner et al., 2023, p. 995).

Importantly, ableism also shows up in less obvious ways, such as a misinterpretation or reinterpretation of client's struggles (as opposed to outright dismissal) (Hallett & Kerr, 2020), or the "couch[ing] of ableism in expressions of concern, pieces of advice, or criticisms of others with…disabilities" (Max, 2017, p. 57). In another seemingly innocuous or well-meaning example, practitioners sometimes lead with narrow interpretations of clients' resilience. These individualized ('bootstrap') understandings place implicit demands on disabled people to use their courage and willpower to 'overcome' their disability and any obstacles related to it, without due consideration of systemic barriers (Benton, 2023). Brodt (2023) encourages us to re-examine and divest from such conceptions. Allowing ourselves to be touched by disabled people's strengths in a non-distorted way is necessary if we are to accompany them in a therapeutic process.

Working Relationally: Trauma-Informed Practice and the Therapeutic Alliance

Trauma-Informed Practice

It would be inaccurate to assume that all Mad, disabled, and neurodivergent people will experience trauma (Eales, 2019). However, simply existing in an ableist and sanist world, simply attempting to meet basic needs or to thrive in unforgiving contexts, is often traumatic for these groups. Neurodivergent people are more likely to experience trauma and abuse than their counterparts (Bowers & Widdowson, 2023), as are Mad and disabled people (Andrews, 2019; Conner et al., 2023; Max, 2017). Importantly, trauma itself (e.g. accident, injury, violence) can lead to disability, revealing ever-evolving, complex interconnections between trauma and disability (Andrews, 2019). In a testament to the need for a trauma-informed approach when working with these groups, a client with chronic, life-threatening illness reported on their emotional life in the following way: "I could not explain how it felt emotionally [back then]

because it took years before my feelings grew back" (Richards, 2008, p. 1720, as cited in Benton, 2023). In considering the use of trauma-informed practice, I take my cue from Eales (2019), a Mad queer dance artist, who states that practitioners of the helping professions can have "good intentions and dangerous practices… based on normative (even evidence-based) assumptions about what is beneficial" (p. 158).

A nuanced trauma-informed practice is therefore crucial when working with disabled, Mad, and neurodivergent clients, and could, like trauma-informed practice generally, benefit all clients. For example, validating a client's distress, providing appreciation for a client's courage in arriving at counseling, acknowledging their successes (of any size), and holding hope that "future good things are possible" (Briere & Scott, 2014, p. 98) are all within the scope of trauma-informed practice. In addition, trauma-informed practitioners normalize clients' altered capacity for information processing and other adaptations (Briere & Scott, 2014).

Principles of trauma-informed care as outlined by SAMHSA (2014) and Eales (2019) include: 1) establishing client's immediate safety, 2) building trustworthiness and transparency through practitioner's actions; 3) providing avenues for peer support and mutual self-help; 4) creating possibilities for connection and collaboration in session; 5) recognizing client inherent agency and expression, their strengths and choice; and 6) recognizing and addressing historical trauma and practitioner biases, while providing culturally-responsive care (SAMHSA, 2014).

Widely-used trauma-informed techniques include: consent practices, pacing, titration, and pendulation, among others (Malchiodi, 2015). Co-creating 'process contracts' is also useful (Bowers & Widdowson, 2023). In establishing a 'process contract,' the client is not only observed for their state of regulation, arousal, or affect, but they become part of the process of co-regulating and tracking, thereby providing input on the sessions' pace and direction. If

therapy with disabled or neurodivergent clients is coming to an end altogether, particular attention to clients' relational trauma and chronic isolation (if any) is warranted during the closing process (Statham & Beail, 2018). Ensuring there is buffer time at the end of sessions, taking into account cognitive load, task-switching, and emotional intensity, is also important. Feelings of being 'too much' or 'not enough' or 'incompetent' commonly occur for Mad, disabled, and neurodivergent clients. This potentially fuels avoidance patterns or low expectations related to goals and tasks, which has direct implications to therapeutic intention-setting (Bowers & Widdowson, 2023). Systemic isolation, ableism in relationships, and difficulties with social cues, all negatively impact relationships and can lead to expectations of rejection, which has implications for transference and the therapeutic relationship (Bowers & Widdowson, 2023).In the case of expectations of rejection, Bowers and Widdowson (2023) suggest enquiring about the client's assumptions regarding the therapist's reactions, asking about cues or evidence on which the client bases these assumptions, and maintaining a nonjudgmental stance.

Importantly, a trauma-informed practice which individualizes trauma and obscures trauma's roots in colonization and structural oppressions fails to provide authentic containment for clients (Dupuis-Rossi & Reynolds, 2018). Certain kinds of disability-related trauma (for example, state-enforced poverty, lack of stable housing and employment, trauma from institutionalization or coercive care, the complex impacts of MAID legislation in Canada, disablement due to climate crisis, pandemics, and working conditions, etc.) become unreadable if trauma is individualized and pathologized (Eales, 2019). On the other hand, intersectional and sociopolitical approaches to trauma take into account microaggressions and the connections between social, cultural, personal, and systemic contexts leading to trauma (Eales, 2019).

In one example, neurodivergent clients may experience the impacts of trauma (and subsequent nervous system responses) differently than their neurotypical counterparts, requiring access-driven, trauma-informed practices which include a "neurodiversity lens" (Trauma Geek, para. 13). Meltdowns and shutdowns (which often involve sensory overload, cognitive overload, and managing change or unpredictability) and burnout (which often results from masking, over-adapting, and trauma) are common experiences for neurodivergent clients. These are different from anxiety, panic attacks, phobias, or other forms of distress, although they may co-occur. Placing trauma-induced, masking-induced, or environment-induced responses in wider contexts is crucial for trauma-informed practice with neurodivergent clients (Hallett & Kerr, 2020). Refraining from shaming clients for self-regulating or coping mechanisms is key (Bowers & Widdowson, 2023). Additionally, anxiety, panic, or other distress may not present in typical, visible ways for autistic clients (for example, there may be less external cues indicating distress). This illuminates the need for trauma-informed practitioners to bracket assumptions about the cause of distress, to check in regularly, to believe clients when it comes to distress (regardless of the client's level of emoting), and to understand how distress and trauma and intersect with the autistic experience (Hallett & Kerr, 2020**).**

In a second example, Eales (2019) examines the widely-used Progressive Muscle Relaxation (PMR) which, when instructed uncritically, contains expectations about what causes relaxation, what relaxation feels like, which body parts people have, and the capacities of these body parts to sense, contract and release. Uncritical instruction becomes damaging to people whose non-normative bodyminds are sites of pain and trauma (Eales, 2019). Similarly, Conner et al. (2023) concludes that mind-body interventions (e.g. mindfulness, meditation, and relaxation) can bring clients' attention to their physical pain in unhelpful ways. Encouraging neurodivergent

people to ‘ground themselves’ using these techniques in situations of sensory overload or unsafety might lead to further dysregulation, exposure, or fear (Bowers & Widdowson, 2023). This highlights the need for consent, a tailored approach, and increased training for practitioners using somatic or sensory-based approaches with clients with disabled and neurodivergent bodyminds (Conner et al., 2023). Doing things differently requires expansive, creative possibilities and the development of a more “consciously porous and non-normalizing” (Eales, 2019, p. 164) somatic activity.

In a third example of trauma-informed practice, disabled clients may hold feelings of grief as a result of social and economic marginalization (Benton, 2023) or grief related to the state of, limits of, or changes to, their bodymind. The question of grief and loss in the context of disability is complex, and an intersectional trauma-informed approach equips us to meet the client more fully. We are more likely to cause harm if we impose a linear process of grieving involving ‘stages of acceptance,’ or if we attribute loud emotional responses to ‘maladjustment,’ without considering layered impacts of environment, power dynamics, exclusion and other circumstances (Andrews, 2019). We are less likely to cause harm in session if we validate the clients’ grief and pain while also naming, for example, the trauma resulting from ableist tragedy narratives, and related associations of deficiency attached to disabled bodyminds (Benton, 2023).

Lastly, amidst polarizing discourse, being trauma-informed requires a full accounting of the impacts of the ongoing COVID-19 pandemic on disabled people and all people, including the traumas that counsellors and our clients have endured throughout the pandemic (L. Guenzel, personal communication, April 1, 2024).

Eales (2019) offers suggestions for a Mad-accessible, anti-oppressive, trauma-informed movement practice for working with disabled and Mad people. These practices are at once anti-

sanist, anti-ableist, anti-racist, anti-fatphobic, as well as LGBTQ2S+ and trans-affirming (Eales, 2019). Although this author is not a practitioner in the psy disciplines, her suggestions for trauma-informed practice can be fruitfully applied here and may have particular relevance to somatic therapeutic interventions. Eales (2019)'s suggestions include: recognizing privilege while challenging pathologization, normalization, sanism, and other structural inequities; doing our own homework; valuing marginalized perspectives, histories, struggles, and choices; shifting language; and shifting environments.

The Therapeutic Relationship: Growing a Disability-Affirming Alliance

Bowers and Widdowson (2023) suggests that the therapeutic relationship may be the first time that a neurodivergent or disabled client has felt safe enough to be authentic, to express, or to reveal themselves without fear of others' judgment or expectation. This highlights the utmost importance of simply being with the client – of the relationship itself and the trust carefully built within it. To that end, a disability-affirming alliance is made possible through a foundation of basic counselling skills and person-centered practice (including skills of validation, empathy, and positive regard, among others). The importance of an affirming alliance is well-known in literature regarding therapies in other marginalized groups (Max, 2017), and as Conner et al. (2023) puts it, "these foundational counseling skills dovetail with a non-ableist stance to create an affirming space for disabled clients" (p. 993). In addition, co-creation, or establishing oneself as a ready and able collaborator (Hallett & Kerr, 2020), is important in growing this alliance. As with any client, building a shared language and ongoing conversation around expectations, goals, and amount of structure in sessions, is also vital.

Troubles in establishing this alliance typically arise through practitioner's lack of knowledge and sensitivity. This is legible in practitioners who are overly sympathetic ("Wow,

that sounds really terrible") in place of empathic inquiry ("Well, it sounds like you're in a lot of pain. Can we talk about that pain?") (Conner et al., 2023, p. 991). Other impediments to a disability-affirming alliance include microaggressions such as overfocusing on client's diagnostic label, actively pathologizing the client, attempting to modify clients' behaviours at the expense of knowing their needs, and offering misguided suggestions (Bowers & Widdowson, 2023). For neurodivergent clients, these microaggressions can lead to a client's masking or selecting-out parts of themselves in order to show up to sessions (Bowers & Widdowson, 2023). Bowers and Widdowson (2023) suggests shifting from 'management' of neurodivergence towards relationship-building and shame-reduction. We can also be mindful of our own internal responses which pull us to invite a client's over-adaptation, appeasement and collapse (Bowers & Widdowson, 2023). Similarly, Mad clients describe being placed in the position of limiting their emotional expression for their counsellor's comfort, or managing or and anticipating their counsellor's reactions (Max, 2017). These cycles of conforming and reacting invite shame and exhaustion for clients, repeated mis-attunement and missed relationship opportunities, and outright relational rupture. Multiple authors note that an affirming alliance for disabled, Mad and neurodivergent clients requires sufficient training and experience (Flor, 2018), and the ongoing building of practitioner's disability-related knowledge (and overall comfort with disability) through self-education (Hallett & Kerr, 2020). More important than training, according to Bowers and Widdowson (2023) is an attunement to the *needs, lived experience,* and *inner world* which lay beneath outward-presenting symptoms and behaviours.

Multiple studies reporting on disabled clients' perspectives illustrate the need for certain qualities from the therapist in order to enhance the therapeutic alliance. These include: 1) *curiosity* around the clients' everyday interests, their lived experience of disability, their

relationships, and their community (knowing that clients are the experts on their own bodyminds and needs, and that disability, neurodivergence and Madness will feel different for each client) (Bowers & Widdowson, 2023; Conner et al., 2023); 2) *understanding, acceptance, nonjudgment* and, when needed, explicit reassurance that there is no wrong way to be or behave; 3) *validation* of the client's struggles related to being disabled, Mad, and neurodivergent in a world built for nondisabled and neurotypical people (Hallett & Kerr, 2020); 4) *responsiveness* to the disability-related content brought by the client rather than ignoring or flattening this content (Conner et al., 2023); 5) *welcoming and celebrating* neurodivergent, Mad, and disabled traits, acknowledgment of the gifts and complexities of these bodyminds (e.g. 'hyper-focus,' 'hyper-empathy,' 'hyper-porousness,' special interests, creativity, adaptations) (Bowers & Widdowson, 2023); 7) a stance of *openness*, allowing oneself to be impacted by the client (Bowers & Widdowson, 2023); 8) *directness* in asking what the client needs or wants, and/or *enabling client self-advocacy or self-leadership* by inviting a client to name what they need in session (knowing that clients may or may not feel safe enough to ask questions or make requests) (Hallett & Kerr, 2020); and 9) *flexibility* in approach, including openly discussing what's helpful, encouraging multiple modes of expression, and finding creative solutions when needed (Hallett & Kerr, 2020). These qualities allow for enough safety for clients to unmask and to test unmasked relating patterns in sessions, they give the client permission to 'not understand', to get things 'wrong' and to be uncertain in session, and they provide a foundation for tending to the impacts of previous rejection in relationships (Bowers & Widdowson, 2023).

While it is important for practitioners to grow these qualities and to minimize harm, microaggressions, and other threats to the alliance, it is also important for us to shed expectations of our own perfection as practitioners. Ruptures will inevitably occur. It is the continual process

of seeking feedback from the client (Conner et al., 2023), alongside acknowledging one's impact and ensuring course-correction and re-attunement – repair rather than mastery – which has the potential to strengthen the therapeutic alliance. Repair is not without its complexities, since power dynamics and lack of safety can pose barriers to expression for marginalized clients who might otherwise have feedback to offer (Evans & Randle-Phillips, 2020). Connection with a third person (not the therapist) might provide another pathway for feedback, and might provide information as to why clients stop attending therapy (Evans & Randle-Phillips, 2020).

Importantly, a disability-affirming alliance is beneficial beyond sessions themselves. It has meaningful, material effects in supporting clients to respond to stress and prejudice with their chosen strategies, to practice self-compassion, build an affirming disability identity (if that is their wish), accept the realities of their bodymind, and gain a felt-sense of agency and self-efficacy (Conner et al., 2023). A disability-affirming alliance also begins the slow process of removing the 'conditions of worth' placed on disabled, Mad, and neurodivergent clients in their everyday lives (Max, 2017), paving the way to self-acceptance.

Working Cross-Culturally: Culturally-Responsive Practices

Working with Mad, disabled, and neurodivergent clients requires a working knowledge of, and respect for, the cultures, subcultures, and lineages of these groups (Max, 2017). Disability cultures and communities nourish validation and connection born of shared experience (Conner et al., 2023). Disability cultures are places of mutual support, skill-sharing (Andrews, 2019), and sharp wit (Conner et al., 2023). They also foster disability mentorship and leadership, and provide exposure to cultural icons and role models (Andrews, 2019). Importantly, not all disabled people participate in disability culture for any number of reasons – lack of interest in it, not knowing about it, not having access to disability culture or community, etc. Even so, all

disabled people exist in their unique cultural context, and it is now widely accepted that *all* counselling is a cross-cultural encounter (Arthur, 2018). Building our cultural competencies as practitioners rightly involves building our disability-cultural competencies. Unfortunately, attention to this in the field is almost nil (Conner et al., 2023). Multiple authors have noted the need for improved training and preparation regarding disability as a matter of cultural competency (Benton, 2023). Following Fisher-Borne, et al. (2015), I lean towards cultural humility and cultural responsiveness as processes rather than cultural mastery as an endpoint. This is in part because claims of 'disability specialty' amongst practitioners do not guarantee beneficial experiences for clients. Instead, these claims are potentially informed by outdated, rigid, or inaccurate training, misinformation, as well as *narrow* personal experiences or connection to disabled and neurodivergent people, resulting in a false sense of intimacy and expertise (Hallett & Kerr, 2020). Our homework is to challenge this narrowing so that, as Haydon-Laurelut (2016) puts it: "therapists … hold open a space for marginalized stories of disability as culture [and] play their part in expanding stories of disabled life" (p. 13). Culturally-responsive work with disabled clients involves creating room for clients to discuss their multiple cultural and linguistic identities, any spaces where they feel belonging, as well as any intersecting experiences of oppression (Andrews, 2019). Importantly, Andrews (2019) points to prescriptions for 'disability etiquette' (e.g. holding tightly to the use of particular language) in the psy disciplines, which are not helpful. The author distinguishes these prescriptions from a strong internal and relational foundation, which allows us to work with complex contexts and make culturally-effective clinical decisions. Conner et al. (2023) frames it this way:

> Disability cultural competencies and humility require nondisabled [practitioners] to reflect on their nondisabled privilege and inherent ableism in their work. [Practitioners]

> with disabilities can also reflect on their internalized ableism. Importantly, a disability culture framework combined with active self-reflection may allow [practitioners] to affirmatively explore disability culture and community with clients (p. 992)

Andrews (2019) identifies ingredients for culturally-responsive work with disabled clients, including: 1) placing the client at the center of their own care, in ways that realize a client's dignity, self-determination and choices, achieved through processes of transparency, collaboration, and the tailoring of interventions; 2) ongoing self-reflection and self-assessment by practitioners, including knowing one's own biases, beliefs, and emotional reactions (as described earlier in this chapter); 3) adopting a stance of cultural humility; 4) recognizing a client's pathways to thriving, including their self-understood strengths, skills and achievements, their values-based actions, expressed ambitions, spiritual world, and their sexuality and pathways to pleasure; 5) recognizing signs of violence, trauma, enforced dependencies, or minority stress; 6) supporting clients in naming and contextualizing oppressive experiences, and normalizing emotional responses to these experiences which might otherwise be dismissed, such as rage; 7) supporting clients in finding affirming spaces and relationships, referring to peer-led networks when appropriate; 8) understanding clients' rights as laid out in law and policy; 9) clarifying our role in consensual advocacy/solidarity with the client and taking action where appropriate; and 10) understanding our own ethical and legal obligations to provide accommodations, obtain rolling consent using shared language with the client, and provide treatment within the bounds of our competency.

Practitioners themselves might have lived experience of disability, Madness, or neurodivergence, providing them firsthand knowledge or membership in disability culture(s). It is deeply important to ensure a fuller representation of counsellors with lived experience of this

kind, who are so far woefully underrepresented in the psy- disciplines (Lund, 2022). This connects us with another principle of Disability Justice: *Leadership of those most impacted.* Yet even in the case of practitioners' own lived experience, we must ensure that we as disabled practitioners don't conflate our experiences with those of our client. We may draw from our own experience, yet we are charged with skillfully signaling differences where these exist (Polanco, 2013), deepening our practices of humility, examining internalized ableism, ensuring thoughtful self-disclosure Max (2017), centering the client's own experience, and holding lightly any knowledge we have gathered over time. Further, in order to ensure ongoing cultural responsiveness with disabled clients, all practitioners must receive supervision on a regular basis from colleagues, and consult with, and be in authentic relationship with, community members with lived experience to the best of their ability (Benton, 2023).

Persistent Collective Access

I take my cue from (Brodt, 2023) who calls for 'persistent access' in our counselling practices. Persistent access occurs in ways that benefit disabled, Mad, and neurodivergent people *and all people,* known as the 'curb cut effect' (Hamraie, 2017). Similarly, universal design, which ensures that an environment, a service, or product can be "accessed, understood and used to the greatest extent possible by all people," *not just* for the benefit of a small fraction (The Centre for Excellence in Universal Design, 2024, para 1) could be brought more fully to the psy disciplines, though literature on this is scarce to date (Benton, 2023). In an example of the curb cut effect, one practitioner reflected that the need for clarity from her autistic clients has prompted increased clarity with all of her clients (Hallett & Kerr, 2020). Persistent, collective access requires a shift away from a solely medicalized understanding of disability in counselling,

and away from the harmful lens of disability-needing-remediation (Brodt, 2021). As one disabled client states:

> I feel like [practitioners] were always trying to cure me. Now my current therapist is actually saying, "No, you have all the right to feel anxiety," or, "Your body pain is okay." It's like they're moving towards a model of accepting who I am, instead of like, "We need to get you on meds. We need to get rid of this," kind of thing… They're saying no—that it's a lot of things that are happening, multiple players and multiple dynamics that shape our disabilities, and that limit our participation, and it's not only up to us, it's up to everybody (Conner et al., 2023, p. 990)

Relying on the medical model means that resources (money, time, attention, etc.) are erroneously directed towards disabled people only, missing others who might benefit (Brodt, 2021). Instead, allocating resources toward changes in the material environment, institutional structures and policies (Brodt, 2021) as well as culture and ways of relating, gives rise to a range of possibilities and ensures persistent access for all. Access practices exist in multiple intersecting and overlapping domains, including but not limited to: the built environment (e.g. ramps, doors, universal washrooms (Hamraie, 2017)); the sensory environment (e.g. sound, smell, allergens (Brilmyer et al., 2023)); modes of communication; and process-based and relational forms of access (for example, pacing, ensuring multiple entry points to participating in an activity, establishing access intimacy with a friend (Tastrom, 2019)).

Persistent collective access also challenges the default of providing accessibility when it's most convenient or profitable. We have seen the evaporation of access practices when only a few people, instead of everyone, seem to be impacted. In one example of this, at the onset of the pandemic, community leaders rightly ensured remote access to work and community events

(Abbott, 2020; Herbst, 2020), and government grants ensured basic income (for some) above the level of poverty. These measures have been largely removed despite ongoing need for them – including the usefulness of these measures for multiple marginalized groups regardless of the ongoing pandemic, as well as continued need to mitigate risks of COVID and long-COVID. There are many who continue to advocate for a liveable income, and for online options for work, learning, and socializing (Disability Without Poverty, 2024). There are also many who advocate for clean indoor air in schools and other settings, masking in health care settings and other settings, and other infrastructure to enable us to prepare for climate crisis and other pandemics (Protect Our Province BC, 2024). Persistent access requires us to resist reverting to what's convenient – to continue to push for the access practices which we know are needed by multiple groups, and which we know are possible (Brodt, 2023).

There is no single approach or adaptation which meets the needs of all disabled, Mad, and neurodivergent clients. Therefore, authors suggest that early, often, and ongoing adaptations are needed (Hallett & Kerr, 2020). These adaptations ought not to be based on client's symptoms or diagnosis alone, on a specifically modified protocol, or on an accessibility checklist (though the following paragraphs might read as a long checklist indeed!). Instead, adaptations ought to be based on clients' underlying needs, goals, and desires for therapy. Importantly, valued adaptations hinge on practitioner's clear, flexible approach, as well as their heartfelt openness and collaboration. Not only this, practitioners must have lightly-held, ongoingly updated understandings of disability informed by those with lived experience (Hallett & Kerr, 2020), highlighting the need to get to know the client, to develop a tailored approach (Anderberg et al., 2017), and familiarize oneself with community knowledges (Bowers & Widdowson, 2023).

To begin, clients have reported on the need for information about the physical setting of counselling, transportation options, payment options, openness to service animals, and the process of the counselling itself, *before* booking sessions (Andrews, 2019; Conner et al., 2023, Toor, 2019). Counsellors and organizations can indicate in their public advertisements the ways that their space or practices are access-centered (or not) (Andrews, 2019). A lack of information about accessibility is considered not just inconvenient for disabled clients, but tantamount to discrimination (Brodt, 2023). Next, adaptations in the built environment are essential for disabled, neurodivergent, Mad, and trans or nonbinary clients, among others. These include: accessible parking spaces, barrier-free pathways, ramps, elevators, wide-enough hallways and wide-enough doors with buttons, universal and gender-neutral washrooms (Conner et al., 2023; Hallett & Kerr, 2020); various seating options and configurations to ensure comfort and optimal distance/closeness between people (Hallett & Kerr, 2020); openness to meeting in alternate locations (Conner et al., 2023); and finally, items for fidgeting, stimming, soothing, or creative flow. Attention to the sensory environment (e.g. reduced sounds and smells, adjustable lighting, and the absence of chemicals, smoke, or allergens) is also important for clients across groups.

Adaptations regarding logistics include: offering multiple modes of communication during and outside of sessions (e.g. providing the option of video, phone, or in person, offering the use of the chat, raised hand functions and emojis for online appointments, and providing translation when needed); ensuring accessible formats for all materials, plus offering materials developed by neurodivergent, Mad, and disabled people themselves (Benton, 2023); support in making and keeping appointments, providing reminders, or offering flexible appointment schedules and session lengths; support in completing administrative procedures such as insurance, with moveable deadlines if possible (Hallett & Kerr, 2020); flexibility (or refraining

from chastisement, at the very least) for late arrivals or cancellation for health-related reasons (Conner et al., 2023); and low-cost or sliding scale options.

Finally, relational and process-based forms of persistent access ensure that the therapeutic process is both *accessible* and *meaningful* to the client (Woolfall, 2018). Relational access occurs through ongoing inquiry about what the client needs in order to participate, engage, feel present and safe-enough. Adaptations include: flexibility in both *approach* and ways of *thinking* (Hallett & Kerr, 2020); adjusting the pace and structure of sessions as needed (Bowers & Widdowson, 2023); allowing for extra time to settle in or to close sessions; ensuring multiple ways of participating in an activity or homework, ensuring tasks and materials are practical and concrete when needed, as well as relevant and client-led, with clear instruction (Hallett & Kerr, 2020, Patterson et al., 2020) ; providing experiential, interactive activities, using modelling for learning or practicing new skills (Woolfall, 2018); providing opportunities to write notes before during or after sessions; opening multiple pathways for feedback (Evans & Randle-Phillips, 2020); and bringing in a third person as a support or access buddy, and/or a third person to whom the client can relay feedback.

Persistent, collective access has been repeatedly framed as love-in-action by Disability Justice cultural workers (Piepzna-Samarasinha, 2018). It is important not to romanticize the need for access, or to diminish the material and structural changes needed for access (Sayre, 2022). However, cultural, relational, and internal transformation is just as necessary for access to be realized. Love itself is wholly necessary for survival, for thriving and reciprocity within communities – and for a truly meaningful, equitable relationship with disabled, Mad, and neurodivergent clients. When collective access comes from a place of love, we as practitioners more fully consider our heartfelt intentions, our roles within broader systems, and we choose to

operate “from a model of solidarity not charity” (Piepzna-Samarasinha, 2019, p. 41). Our work becomes more affirming, accessible, and invitatory for all (Eales, 2019).

Limitations and Final Conclusion

There continue to be gaps in literature not fully addressed by this capstone, and more investigation is needed in the areas of: lived experiences of disabled, Mad, and neurodivergent clients not mentioned here, including aging clients, Deaf clients, and blind clients; valued adaptations to existing therapies not mentioned here, including widely known approaches such as Internal Family Systems; and common factors in these client groups, with further insight needed on the therapeutic alliance, relationship ruptures and repair.

Within this capstone, I investigated the ways in which Disability Justice (as both a framework and a way of working) might be brought to counselling in order to support disabled, Mad, and neurodivergent clients, as well as all clients. In my literature review I provided an overview of how disabled, neurodivergent, and Mad people have experienced counselling, as well as an overview of intervention effectiveness. In this final chapter, I outlined recommendations for practice based on these findings and based on six principles of Disability Justice. Excitingly, there is great opportunity to flesh these out further, and to consider the remaining four principles. I ended on a note which I consider to be of utmost importance - the vital role of our love-in-action, as counsellors and as human beings in this world.

References

Abbass, A., Lumley, M. A., Town, J., Holmes, H., Luyten, P., Cooper, A., Russell, L., Schubiner, H., De Meulemeester, C., & Kisely, S. (2021). Short-term psychodynamic psychotherapy for functional somatic disorders: A systematic review and meta-analysis of within-treatment effects. *Journal of Psychosomatic Research*, *145*, 110473

Abbott, I. (2020, April 10). *A letter to my abled friends.* Medium. https://medium.com/@isabelfaithabbott/a-letter-to-my-abled-friends-e37e55c151

American Psychological Association, APA Task Force on Guidelines for Assessment and Intervention with Persons with Disabilities. (2022). Guidelines for Assessment and Intervention with Persons with Disabilities. https://www.apa.org/about/policy/guidelines-assessment-intervention-disabilities.pdf

Anderberg, E., Cox, J., Neeley-Tass, S., Erekson, D., Gabrielsen, T., Warren, J., Warren, J. S., Cline, J., Petersen, D., South, M. (2017). Sticking with it: Psychotherapy outcomes for adults with autism spectrum disorder in a university counseling center setting. *Autism Research, 10,* 2048-2055.

Andrews, E. E. (2019). *Disability as diversity: Developing cultural competence*. Oxford University Press, USA.

Andrews, E. E., Forber-Pratt, A. J., Mona, L. R., Lund, E. M., Pilarski, C. R., & Balter, R. (2019). # SaytheWord: A disability culture commentary on the erasure of "disability". *Rehabilitation Psychology*, *64*(2), 111

Archibald, L. (2021, September 23). *Mad activists: The language we use reflects our desire for change.* Mad in America: Science, psychiatry and social justice. https://www.madinamerica.com/2021/09/mad-activists-langauge/

Arthur, N. (2018). Infusing culture and social justice in ethical practices with all clients. In N. Arthur (Ed.), *Counselling in cultural contexts* (8th ed., pp. 3-28). Springer Nature. https://doi.org/10.1007/978-3-030-00090-5

Ashworth, S., Mooney, P., & Tully, R. J. (2017). A case study demonstrating the effectiveness of an adapted-DBT program upon increasing adaptive emotion management skills, with an individual diagnosed with mild learning disability and emotionally unstable personality disorder. *Journal of Forensic Psychology Research and Practice, 17*(1), 38-60. Doi: http://dx.doi.org.ezproxy.bangor.ac.uk/10.1080/15228932.2017.1251098

Bachmann, K., Lam, A. P., Sörös, P., Kanat,M., Hoxhaj, E.,Matthies, S., Feige, B., Müller, H., Özyurt, J., Thiel, C. M., & Philipsen, A. (2018). Effects of mindfulness and psychoeducation on working memory in adult ADHD: a randomized, controlled fMRI study. *Behaviour Research and Therapy, 106,* 47–56.

Benton, M. K. (2023). *The state of psychological services for people with physical and cognitive disabilities: an integrative systematic review*. [Doctoral dissertation, Pepperdine University].

Berne, P., Morales, A. L., Langstaff, D., & Invalid, S. (2018). Ten principles of disability justice. *WSQ: Women's Studies Quarterly*, *46*(1), 227-230.

Bowers, C., & Widdowson, M. (2023). Transactional analysis psychotherapy with clients who are neurodivergent: Experiences and practice recommendations. *International Journal of Transactional Analysis Research and Practice*, *14*(1).

Brilmyer, G., Apolloni, A., Bloom, M., Uribe, T., & Bagood, A. (2023). *Accessible spaces, a fragrance free toolkit*. UCLA Center for the Study of Women. https://csw.ucla.edu/toolkit

Brodt, M. (2023). Cyborg oracles: insights for counseling psychology from the disability justice movement post COVID. *Counselling Psychology Quarterly*, *36*(2), 169-188.

Byrne, G., & O'Mahony, T. (2020). Acceptance and commitment therapy (ACT) for adults with intellectual disabilities and/or autism spectrum conditions (ASC): A systematic review. *Journal of Contextual Behavioral Science*, *18*, 247-255.

Cai, R. Y., & Brown, L. (2021). Cultivating self-compassion to improve mental health in autistic adults. *Autism in Adulthood*, *3*(3), 230-237.

Camm-Crosbie, L., Bradley, L., Shaw, R., Baron-Cohen, S., & Cassidy, S. (2019). 'People like me don't get support': Autistic adults' experiences of support and treatment for mental health difficulties, self-injury and suicidality. *Autism*, *23*(6), 1431-1441.

Carvalho, S. A., Skvarc, D., Barbosa, R., Tavares, T., Santos, D., & Trindade, I. A. (2022). A pilot randomized controlled trial of online acceptance and commitment therapy versus compassion-focused therapy for chronic illness. *Clinical Psychology & Psychotherapy, 29*(2), 524-541.

Centers for Disease Control and Prevention (2023, May 15): *Disability impacts all of us.* Disability and Health Data System (DHDS) https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html

Chandler, E., Changfoot, N., Rice, C., LaMarre, A., & Mykitiuk, R. (2018). Cultivating disability arts in Ontario. *Review of Education, Pedagogy, and Cultural Studies*, *40*(3), 249-264.

Clapton, N. E., Williams, J., Griffith, G. M., & Jones, R. S. (2017). 'Finding the person you really are… on the inside' Compassion focused therapy for adults with intellectual disabilities. *Journal of Intellectual Disabilities, 22*(2), 135-153. Doi: https://doi.org/10.1177/1744629516688581

Clarke, C. L. (2020). *The effectiveness of psychological therapies and therapists when working with adults with intellectual disabilities* [Doctoral dissertation, University of Sheffield].

Conner, K. J., Acosta, V. M., Nouri, R., Tyler von Wrangel, M., Gramillo, E., & Conner, A. (2023). Psychotherapy experiences of us adults with physical disabilities: Recommendations for affirmative practice. *The Counseling Psychologist*, *51*(7), 970-1004.

Cooper, R., & Frearson, J. (2017). Adapting compassion focused therapy for an adult with a learning disability—A case study. *British Journal of Learning Disabilities, 45*(2), 142-150. doi:http://dx.doi.org.ezproxy.bangor.ac.uk/10.1111/bld.12187

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics, *University of Chicago Legal Forum,1*(8). Retrieved from: http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/

Crossland, T., Hewitt, O., & Walden, S. (2017). Outcomes and experiences of an adapted dialectic behaviour therapy skills training group for people with intellectual disabilities. *British Journal of Learning Disabilities, 45*(3), 208-216. Doi: http://dx.doi.org.ezproxy.bangor.ac.uk/10.1111/bld.12194

Crow, L. (1996). Including all of our lives: Renewing the social model of disability. In J. Morris (Ed.). *Encounters with strangers: Feminism and disability* (pp. 206-226). London: The Women's Press

Disability Without Poverty (2024).*Welcome to the disability without poverty movement.* Disability Without Poverty. (DWP). https://www.disabilitywithoutpoverty.ca/

Du, J., Diao, H., Zhou, X., Zhang, C., Chen, Y., Gao, Y., & Wang, Y. (2022). Post-traumatic stress disorder: A psychiatric disorder requiring urgent attention. *Medical Review*, *2*(3), 219-243.

Dupuis-Rossi, R., & Reynolds, V. (2018). Indigenizing and decolonizing therapeutic responses to trauma-related dissociation. In N. Arthur (Ed.), *Counselling in cultural contexts: Identities and social justice* (8th ed., pp. 293-315). Springer Nature Switzerland AG. https://doi.org/10.1007/978-3-030-00090-5_13

Eales, L. M. (2019). Making mad home and other love stories: Mad performative autoethnography, collaborative research-creation, and mad-accessible trauma-informed practice [Doctoral dissertation, University of Alberta]

Eales, L., & Peers, D. (2016). Moving adapted physical activity: The possibilities of arts-based research. *Quest*, *68*(1), 55-68.

Efron, S. E. & Ravid, R. (2019). *Writing the literature review : A practical guide.* The Guilford Press.

Erevelles, N. (2011). *Disability and difference in global contexts: Enabling a transformative body politic*. Palgrave Macmillan.

Erkic, M., Bailer, J., Fenske, S. C., Schmidt, S. N. L., Trojan, J., Schröder, A., Kirsch, P., Mier, D. (2018). Impaired emotion processing and a reduction in trust in patients with somatic symptom disorder. *Clinical Psychology & Psychotherapy, 25*, 163–172. http://dx.doi.org/10.1002/cpp.2151

Evans, L., & Randle-Phillips, C. (2020). People with intellectual disabilities' experiences of psychological therapy: A systematic review and meta-ethnography. *Journal of Intellectual Disabilities*, *24*(2), 233-252.

Feliu-Soler, A., Montesinos, F., Gutiérrez-Martínez, O., Scott, W., McCracken, L. M., & Luciano, J. V. (2018). Current status of acceptance and commitment therapy for chronic pain: A narrative review. *Journal of Pain Research*, 2145-2159.

Fine, M. (2019). Critical disability studies: Looking back and forward. *Journal of Social Issues*, *75*(3), 972-984.

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education*, *34*(2), 165-181.

Flor, A. V. (2018). *Psychotherapy with high-functioning autistic adults: Client and clinician perspectives*. [Doctoral dissertation, Immaculata University].

Foley-Nicpon, M., & Lee, S. (2012). Disability research in counseling psychology journals: A 20-year content analysis. *Journal of Counseling Psychology, 59*(3), 392–398. https://doi.org/10.1037/a0028743

Fullen, T., Jones, S. L., Emerson, L. M., & Adamou, M. (2020). Psychological treatments in adult ADHD: A systematic review. *Journal of Psychopathology and Behavioral Assessment*, *42*(3), 500-518.

Gaigg, S. B., Flaxman, P. E., McLaven, G., Shah, R., Bowler, D. M., Meyer, B., Roestorf, A., Corinna Haenschel, C., Rodgers, J., & South, M. (2020). Self-guided mindfulness and cognitive behavioural practices reduce anxiety in autistic adults: A pilot 8-month waitlist-controlled trial of widely available online tools. *Autism*, *24*(4), 867-883.

Gehart, D.R. (2018). *Mastering competencies in family therapy: A practical approach to theory and clinical case documentation* (3rd ed.). Brooks/Cole Cengage Learning. (ISBN 9781305943278).

Ghai, A. (2012). Engaging with disability with postcolonial theory. In D. Goodley, B. Hughes, and L.Davis. (Eds.). Disability and social theory: New developments and directions (pp. 270-286). London: Palgrave MacMillan

Hallett, S. & Kerr, C. (2020) 'You need support, validation, good coping skills. You need and deserve acceptance": Autistic adult experiences of counselling. *Autistic Mental Health & Autistic Mutual Aid Society Edinburgh (AMASE)*. www.autisticmentalhealth.uk/counsellingreport

Hamraie, A. (2017). *Building access: Universal design and the politics of disability*. U of Minnesota Press.

Hardiman, M., Willmoth, C., & Walsh, J. J. (2018). CFT & people with intellectual disabilities. *Advances in Mental Health and Intellectual Disabilities, 12*(1), 44-56. doi: 10.1108/AMHID-07-2017-0030

Haydon-Laurelut, M. A. (2016). Critical systemic therapy: Autism stories and disabled people with learning difficulties. In *Re-thinking autism: Diagnosis, Identity and Equality* (pp. 221-238). Jessica Kingsley Publishers.

Herbst, J. (2020, March 31). *I've asked to work remotely for years. It's painful to watch companies finally comply.* Fast Company. https://www.fastcompany.com/90484423/ive-asked-to-workremotely-for-years-its-painful-to-watch-companies-finally-comply

Hughes L.S., Clark, J., Colclough, J.A., Dale, E., McMillan, D. (2017). Acceptance and commitment therapy (ACT) for chronic pain: A systematic review and meta-analyses. *The Clinical Journal of Pain, 33*(6): 552–568.

Holley, L. C., Stromwall, L. K., & Bashor, K. E. (2012). Reconceptualizing stigma: Toward a critical anti-oppression paradigm. Stigma Research and Action, 2(2). doi: 10.5463/SRA.v1i1.9

Imrie, R. (1997). Rethinking the relationships between disability, rehabilitation, and society. *Disability and Rehabilitation*, *19*(7), 263-271.

Jahoda, A., Stenfert-Kroese, B., & Pert, C. (2017). *Cognitive behaviour therapy for people with intellectual disabilities*. London: Palgrave Macmillan UK.

Jones, D. R., Nicolaidis, C., Ellwood, L. J., Garcia, A., Johnson, K. R., Lopez, K., & Waisman, T. C. (2020). An expert discussion on structural racism in autism research and practice. *Autism in Adulthood*, *2*(4), 273-281.

Kafer, A. (2013). *Feminist, queer, crip.* Indiana University Press.

Karrouri, R., Hammani, Z., Benjelloun, R., & Otheman, Y. (2021). Major depressive disorder: Validated treatments and future challenges. *World Journal of Clinical Cases*, *9*(31), 9350.

Kelly, C., & Chapman, C. (2015). Adversarial allies: Care, harm, and resistance in the helping professions. *Journal of Progressive Human Services*, *26*(1), 46-66.

Kelly, C. (2020). *An exploration into the use of psychotherapy with intellectually disabled clients*. [Master's thesis, Dublin Business School].

Knowlton, C. N., Kryvanos, A., Poole, M., Christopher, M., & Lafavor, T. (2019). Acceptance and commitment therapy for the treatment of chronic pain and coexisting depression: A single-case study. *Clinical Case Studies*, *18*(4), 254-269.

Krivzov, J., Baert, F., Meganck, R., & Cornelis, S. (2021). Interpersonal dynamics and therapeutic relationship in patients with functional somatic syndromes: A metasynthesis of case studies. *Journal of Counseling Psychology*, *68*(5), 593.

Lewis, T. A. (2022, January 1). *Working definition of ableism - January 2022 update*. Turning into self. https://www.talilalewis.com/blog/working-definition-of-ableism-january-2022-update

Linton, S. (1998). Disability studies/not disability studies. *Disability & Society, 13*(4), 525-539.

Lipinski, S., Blanke, E., Suenkel, U., & Dziobek, I. (2019). Outpatient psychotherapy for adults with high-functioning autism spectrum condition: Utilization, treatment satisfaction, and preferred modifications. *Journal of Autism and Developmental Disorders, 49*(3), 1154-1168. https://doi.org/10.1007/s10803-018-3797-1

Liu, C. I., Hua, M. H., Lu, M. L., & Goh, K. K. (2023). Effectiveness of cognitive behavioural-based interventions for adults with attention-deficit/hyperactivity disorder extends beyond core symptoms: A meta-analysis of randomized controlled trials. *Psychology and Psychotherapy: Theory, Research and Practice*, *96*(3), 543-559.

Lopez, P. L., Torrente, F. M., Ciapponi, A., Lischinsky, A. G., Cetkovich-Bakmas, M., Rojas, J. I., et al. (2018). Cognitive-behavioural interventions for attention deficit hyperactivity disorder (ADHD) in adults. *Cochrane Database of Systematic Reviews, 3*, CD010840. https://doi.org/10.1002/14651858.CD010840.pub2.

Lund, E. M. (2022). Valuing the insider-professional perspective of disability: A call for rehabilitation psychologists to support disabled psychologists and trainees across the profession. *Rehabilitation Psychology*, *67*(4), 582.

Malchiodi, C. A. (2015). Trauma-informed art therapy and group intervention with children from violent homes In C. A. Malchiodi (Ed.) *Creative Interventions with Traumatized Children* (2nd ed., pp. 24-44). Guilford

Max, A. (2017). *The experiences of individuals with psychological disabilities in attending counselling: A phenomenological investigation* [Doctoral dissertation, Université d'Ottawa/University of Ottawa].

Maye, M., Boyd, B. A., Martínez-Pedraza, F., Halladay, A., Thurm, A., & Mandell, D. S. (2021). Biases, barriers, and possible solutions: Steps towards addressing autism researchers under-engagement with racially, ethnically, and socioeconomically diverse communities. *Journal of Autism and Developmental Disorders*, 1-6.

Mazurek, M. O., Pappagianopoulos, J., Brunt, S., Sadikova, E., Nevill, R., Menezes, M., & Harkins, C. (2023). A mixed methods study of autistic adults' mental health therapy experiences. *Clinical Psychology & Psychotherapy*, *30*(4), 767-779.

McCormack, L., Wong, S. W., & Campbell, L. E. (2023). ‘If I don’t do it, I’m out of rhythm and I can’t focus as well’: Positive and negative adult interpretations of therapies aimed at ‘fixing’ their

restricted and repetitive behaviours in childhood. *Journal of Autism and Developmental Disorders*, *53*(9), 3435-3448.

McRuer, R. (2006). *Crip theory: Cultural signs of queerness and disability*. NYU Press.

Mingus, M. (2017, April 27). Access intimacy, interdependence and disability justice. Leaving Evidence. https://leavingevidence.wordpress.com/2017/04/12/access-intimacy-interdependence-and-disability-justice .

Mitchell, J. T., McIntyre, E.M., English, J. S., Dennis, M. F., Beckham, J. C., & Kollins, S. H. (2017). A pilot trial of mindfulness meditation training for ADHD in adulthood: Impact on Core symptoms, executive functioning, and emotion dysregulation. Journal of Attention Disorders, 21(13), 1105–1120. https://doi.org/10.1177/1087054713513328.

Morris, J. (1993). Feminism and disability. *Feminist Review, 43,* 57-70.

Myers, L., Sarudiansky, M., Korman, G., & Baslet, G. (2021). Using evidence-based psychotherapy to tailor treatment for patients with functional neurological disorders. *Epilepsy & Behavior Reports*, *16*, 100478.

Nario-Redmond, M. R. (2019). *Ableism: The causes and consequences of disability prejudice.* Wiley. Hoboken, NJ: http://dx.doi.org/10.1002/9781119142140

Öksüz, E. E. & Brubaker, M. D. (2020). Deconstructing disability training in counseling: a critical examination and call to the profession. *Journal of Counselor Leadership and Advocacy*, *7*(2), 163-175

Oliver, M. (1990). *The politics of disablement. London:* The MacMillan Press Ltd.

Olkin, R. (2017). *Disability-affirmative therapy: A case formulation template for clients with disabilities*. Oxford University Press.

Olkin, R. (2020). Disability-Affirmative Therapy. In: D. Gu & M. Dupre (Eds.), *Encyclopedia of Gerontology and Population Aging.* Springer. doi.org/10.1007/978-3-319-69892-2_488-1

Overboe, J. (1999). Difference in itself: Validating disabled people's lived experience. *Body and Society, 5*,17–29. doi:10.1177/1357034X99005004002

Pahnke, J., Hirvikoski, T., Bjureberg, J., Bölte, S., Jokinen, J., Bohman, B., & Lundgren, T. (2019). Acceptance and commitment therapy for autistic adults: An open pilot study in a psychiatric outpatient context. *Journal of Contextual Behavioral Science*, *13*, 34-41.

Polanco, M. (2013). Cultural democracy: Politicizing and historicizing the adoption of narrative practices in the Americas. *International Journal of Narrative Therapy & Community Work (1),* 29-33.

Patterson, C. W. (2019). *Examining psychological therapies adapted for adults with intellectual disabilities*. [Doctoral dissertation, Bangor University].

Patterson, C., Williams, J., & Jones, R. S. (2020). DBT and intellectual disabilities: The relationship between treatment fidelity and therapeutic adaptation. *Advances in Mental Health and Intellectual Disabilities*, *14*(3), 61-67.

Petkari, E., Nikolaou, E., Oberleiter, S., Priebe, S., & Pietschnig, J. (2024). Which psychological interventions improve quality of life in patients with schizophrenia-spectrum disorders? A meta-analysis of randomized controlled trials. *Psychological Medicine*, *54*(2), 221-244.

Piepzna-Samarasinha, L. L. (2019). *Care work: Dreaming disability justice.* Vancouver, B.C.: Arsenal Pulp Press.

Poloczek, A., & Szczerba, J. (2024). The role of pharmacotherapy and psychotherapy in borderline personality disorder: A literature review. *Journal of Education, Health and Sport*, *57*, 203-216.

Protect Our Province BC (2024, April 17). *BC health advocates call on government to reinstate healthcare mask requirements*. POPBC. https://protectbc.ca/bc-health-advocates-call-on-government-to-reinstate-healthcare-mask-requirements/

Rice, C., Chandler, E., Liddiard, K., Rinaldi, J., & Harrison, E. (2018). Pedagogical possibilities for unruly bodies. *Gender and Education*, *30*(5), 663-682.

Richards, R. (2008). Writing the othered self: Autoethnography and the problem of objectification in writing about illness and disability. *Qualitative Health Research,18*(12), 1717–1728. https://doi.org/10.1177/1049732308325866

Rivas, M. (2020). Disability in counselor education: Perspectives from the United States. *International Journal for the Advancement of Counselling,* 1–16.

Runswick-Cole, K., & Goodley, D. (2013). Resilience: A disability studies and community psychology approach. *Social and Personality Psychology Compass, 7*(2), 67–78.

Sandahl, C. (2003). Queering the crip or cripping the queer? Intersections of queer and crip identities in solo autobiographical performance. *GLQ: A Journal of Lesbian and Gay Studies, 9*(1) (2003): 25-56.

Sayre, D. N. (2022). Care work and social justice in creative arts therapy: Putting queer performance theory and disability justice in conversation with drama therapy. *The Arts in Psychotherapy*, *80*, 101940.

Schalk, S., & Kim, J. B. (2020). Integrating race, transforming feminist disability studies. *Signs: Journal of Women in Culture and Society*, *46*(1), 31-55.

Schweizer, T., Endres, D., Dziobek, I., & Tebartz van Elst, L. (2024). Psychosocial therapeutic approaches for high-functioning autistic adults. *Frontiers in Psychiatry*, *14*, 1265066.

Shepherd, C., & Beail, N. (2017). A systematic review of the effectiveness of psychoanalysis, psychoanalytic and psychodynamic psychotherapy with adults with intellectual and developmental disabilities: Progress and challenges. *Psychoanalytic Psychotherapy*, *31*(1), 94-117.

Sinclair, A., Elwyn, R., Scholz, B., Spandler, H., Maylea, C., Stott, S. B., & Watson, S. (2023). An introduction to the international mad studies journal: A collective reflection on processes, movements, journeys, futures, and unfurlings. *International Mad Studies Journal*, *1*(1), e1-e8.

Singh, A. (2020). Building a counseling psychology of liberation: The path behind us, under us, and before us. *The Counseling Psychologist, 48*(8), 1109–1130.

Sins Invalid. (2019). *Skin, Tooth, and Bone: The Basis of Movement is Our People* (2nd ed.). [Digital version]. Retrieved from https://www.sinsinvalid.org/

Sizoo, B. B., & Kuiper, E. (2017). Cognitive behavioural therapy and mindfulness based stress reduction may be equally effective in reducing anxiety and depression in adults with autism spectrum disorders. *Research in Developmental Disabilities*, *64*, 47-55.

Skelly, A. A., McGeehan, C., & Usher, R. (2018). An open trial of psychodynamic psychotherapy for people with mild-moderate intellectual disabilities with waiting list and follow up control. *Advances in Mental Health and Intellectual Disabilities, 12*(5-6), 153–162. https://doi.org/10.1108/amhid-04-2018-0022

Soraka, A., Kuliesiene, J., & Sapezinskiene, L. (2021). Gestalt psychotherapy for people who have suffered spinal cord injury and are moving by wheelchair. *Šiuolaikinės visuomenės ugdymo veiksniai*, *6*(1), 237-248.

Spade, D. (2020). *Mutual aid: Building Solidarity during this crisis (and the next)*. Brooklyn, NY: Verso.

Statham, V., & Beail, N. (2018). The views of service users on the accessibility, acceptability, and effectiveness of psychodynamic psychotherapy. *International Journal of Developmental Disabilities*, *64*(3), 175-183.

Substance Abuse and Mental Health Service Administration (October 2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.* Publications and Digital Products. https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884

Tastrom, K. (2019, September 13). Relationships not checklists — A theory of accessibility.https://medium.com/@katietastrom/relationships-not-checklists-a-theory-of-accessibility-26e0204b370a

The Centre for Excellence in Universal Design (2024). *About universal design*. The Centre for Excellence in Universal Design (CEUD).https://universaldesign.ie/about-universal-design

Thorneycroft, R. (2020). Crip theory and mad studies: Intersections and points of departure. *Canadian Journal of Disability Studies*, *9*(1), 91-121.

Toor, N. (2019). *An exploration into autistic students' experiences of counselling in university settings*. [Doctoral dissertation, The University of Manchester].

Trauma Geek (2022, January 26). *If your brain is different, your path to healing will be different*. Trauma Geek. https://www.traumageek.com/blog/if-your-brain-is-different-your-path-to-healing-will-be-different

Ulusoy, V., Bilican, I., & Gormez, A. (2024). Effectiveness of an online dialectical behavior therapy skills training in adults with attention-deficit/hyperactivity disorder: A randomized controlled trial. *Psychotherapy Research*, 1-17.

Van Diest, C., Leoni, M., Fisher, N., & Spain, D. (2022). Using EMDR with autistic clients: How do therapists adapt?. *Journal of EMDR Practice and Research*, *16*(3), 123-134.

Violet, T. K. (2022). *"It's hell": Examining suspicion, ableism, and disability pride through an intersectional analysis of fibromyalgia experiences*. [Doctoral dissertation, Bowling Green State University].

Vos, J., & van Rijn, B. (2021). The evidence-based conceptual model of transactional analysis: A focused review of the research literature. *Transactional Analysis Journal*, *51*(2), 160-201.

Walker, N. (2014). *Neurodiversity: Some basic terms & definitions.* Neuroqueer. https://neuroqueer.com/neurodiversity-terms-and-definitions/

Woolfall, E. L. (2018). *The value of third-wave'therapies in intellectual disability services: Service user experiences of adapted dialectical behaviour therapy*. [Doctoral dissertation, Bangor University].

World Health Organization. (2023, March 7). *Disability.* World Health Organization. https://www.who.int/news-room/fact-sheets/detail/disability-and-health

Wright, B. (1983). *Physical disability: A psychosocial approach* (2nd edition). Harper and Row.

Zemestani, M., & Mozaffari, S. (2020). Acceptance and commitment therapy for the treatment of depression in persons with physical disability: A randomized controlled trial. *Clinical Rehabilitation*, *34*(7), 938-947.