Guidelines for Assessment of and Intervention with Individuals Who Have Disabilities

APA Task Force on Guidelines for Assessment and Treatment of Persons With Disabilities

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Acknowledgments

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Additional people will be added.

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The 50 million Americans with disabilities — about 20% of the population — are one of the largest minority groups in the United States (U.S. Census Bureau, 2000). Individuals with disabilities and their advocates have worked for more than 40 years to eliminate attitudinal and physical barriers, to be fully-included in all aspects of society, and to determine their own futures (Jaeger & Bowman, 2005; Priestley, 2001; Switzer, 2008). Their efforts facilitated the passage of the Americans with Disabilities Act (ADA) of 1990 (Americans with Disabilities Act, 1990). However, many people with disabilities continue to encounter both blatant and subtle discrimination in attitudes, employment, housing, education, recreation, health care, and mental health services (e.g., Banks & Kaschak, 2003; Raphael, 2006; Schriner, 2001; Smart, 2001; Stapleton, Burkhauser, & Houtenville, 2004; Waldrop & Stern, 2003; Woodcock, Rohan, & Campbell, 2007).

While many persons who have disabilities have experienced discrimination, each person also assigns a unique meaning to disability as he/she experiences its complex dimensions including pain, fatigue, daily challenges, and social support (Olkin, 1999b; Olkin & Taliaferro, 2005; Vash & Crewe, 2004). Above and beyond their disability experiences, persons with disabilities have their own life experiences. Like everyone else, individuals with disabilities have their own personal characteristics, histories, and life contexts.

To effectively work with people who have disabilities, psychologists need to become familiar with disability-related and other life experiences that influence clients’ psychological well being. Psychologists also have to become aware how their attitudes, reactions, conceptions of disability, and possible biases may affect their professional relationships with clients who have disabilities. Further, it is important for psychologists to learn the best “barrier-free” psychological practices for clients with disabilities, including proper disability “etiquette”, communication skills, provision of reasonable
accommodations, and integration of disability-related issues into assessment and intervention approaches.

Unfortunately, psychologists rarely receive adequate education and training in disability issues (Leigh, Corbett, Gutman, & Morere, 1996; Olkin & Pledger, 2003; Rubino, 2001; Strike, Skovholt, & Hummel, 2004). Few graduate psychology training programs offer disability coursework (Olkin, 2000; Olkin & Pledger, 2003), and this paucity of training is a major barrier to providing effective services to clients with disabilities (Leigh, Powers, Vash, & Nettles, 2004; Olkin, 2002). Limited training and experience may leave many psychologists unprepared to provide clients with disabilities with effective professional services, including assessments and interventions. Psychologists need more disability-related information and training.

The goal of the Guidelines for Assessment of and Intervention with Individuals Who Have Disabilities is to help psychologists design and provide more effective, fair and ethical psychological assessments and interventions with persons with disabilities. The Guidelines provide suggestions about how psychologists can make their practices more accessible and disability-sensitive and enhance their working relationships with clients with disabilities. The Guidelines also describe aspects of living with a disability and other disability relevant information that is often useful to consider when conducting assessments and interventions with clients with disabilities. Additionally, the Guidelines suggest ways psychologists can obtain more education, training and experience about disability.

The Task Force on Guidelines for Assessment and Treatment of Persons with Disabilities based the Guidelines on core values in the Ethical Principles of Psychologists and Code of Conduct (Smart, 2001; Szymanski & Trueba, 1994). The core values include respect for human dignity, recognition that individuals with disabilities have the right to self determination, participation in society, equitable access to the benefits of psychological
services, recognition that people with disabilities are diverse and have unique individual characteristics, and recognition that disability is not solely a biological characteristic, but is also a result of the individual’s interaction with the environment.

The Task Force conducted an extensive literature search of psychological, medical, vocational and educational databases, searching in the areas of professional relationship and communication issues, and assessment and treatment of persons with disabilities. Members searched by selected key words and identified pertinent publications on general disability issues and on a wide range of specific disabilities, including quantitative and qualitative studies, books and book chapters, empirical papers, review articles, case studies, professional papers and standards of practice. The literature review covered a broad scope because it is difficult to integrate the quantitative and qualitative traditions tied to various specialty areas in disability research (e.g., clinical rehabilitation, neuropsychology, education, psychometrics, counseling and vocational rehabilitation). Much of the identified literature was theoretical and professional, focusing on specific disabling conditions rather than generic disability. The Task Force developed methodology to systematically evaluate books, book chapters, and both research and non-research based articles, and to draw recommendations for psychological practice.

These Guidelines are statements that suggest or recommend that psychologists follow specific professional behavior, endeavors, or conduct. Guidelines are not standards. Standards are mandatory and may have an enforcement mechanism. Guidelines are intended to facilitate the profession’s continued systematic development and to ensure that psychologists maintain a high level of professional practice. Guidelines are not exhaustive and may not apply to every professional and clinical situation. They are not definitive and do not take precedence over a psychologist’s well-informed judgment. Applicable federal and state statutes also supersede these Guidelines.
These Guidelines are intended for psychologists who work in various settings with clients who have disabilities. Settings may include outpatient therapy; educational, religious, or correctional facilities; businesses and employment settings; insurance, compensation and legal contexts, and hospital and rehabilitation settings. The Guidelines are intended to facilitate psychologists’ work with clients who have disabilities, not to restrict or exclude any psychologist from serving clients with disabilities or to require specialized certification for this work. The Guidelines also recognize that psychologists who specialize in working with clients who have disabilities may seek more extensive disability training consistent with specialized practice.

There are many methods and ways for psychologists to gain expertise and/or training in working with individuals who have disabilities. The Guidelines do not prescribe following specific training methods, but instead offer recommendations on those areas of knowledge and clinical skills considered applicable to this work.

Disability Awareness, Accessibility, and Diversity

Guideline 1: Psychologists strive to learn about various disability paradigms and models and their implications for service provision.

Disability may be defined from a theoretical, applied or legal perspective; by specific social, administrative and clinical contexts, by attitudes and biases; and by an individual’s self-perception (Altman, 2001; Schultz, Stowell, Feuerstein, & Gatchel, 2007; Smart & Smart, 2007). Generally, disabilities are physical, mental and/or sensory characteristics that affect a person’s ability to engage in activities of daily life (U.S. Department of Health and Human Services, 2005). The ADA defines disability as a physical or mental impairment that substantially limits a major life activity, or having a record of such impairment, or being regarded as having such an impairment in any of the
following areas: physical, systemic, sensory, mental health, learning/cognition, and developmental (ADA, 1990).

Disability diagnoses have important implications for self-identity, eligibility for benefits, social attitudes and actions, legislation, research and clinical practice. Yet, diagnoses are often complicated by the human system affected, age at and type of onset (congenital or acquired), cause, temporary or permanent loss of function, degree of incapacitation, visibility, stigmatization and variability in manifestations (Smart, 2001). To avoid these complications, the functional approach is a pragmatic framework that focuses on what an individual with a disability can and cannot do rather than on a diagnosis. This is a shift away from a pathology-based medical model.

Various models of disability provide psychologists with different ways to think about disability (Altman, 2001; Olkin & Pledger, 2003; Schultz et al., 2007; Smart & Smart, 2007). Each model has different implications for assessment of and interventions with people with disabilities.

The pre-scientific moral model views disability as an embodiment of evil, a punishment for a family member’s or ancestor’s transgression, as a divine gift, or as a test of faith and opportunity to overcome a challenge (Groce, 2005; Mackelprang & Salsgiver, 1999; Olkin, 1999b).

The biomedical model views an individual’s pathological condition or impairment as a medical problem that deviates from the norm (Gill, Kewman, & Brannon, 2003). The model focuses on the person’s deficits and elimination of the pathology or restoration of functional capacity. Most traditional psychological therapies (e.g. behavioral, cognitive-behavioral or psychodynamic) use this model to target symptom removal and adjustment to disability.

The social construction or sociopolitical disability model holds that disability is a product of the interaction between an individual and an environment (DePoy & Gilson, 2004;
This model focuses on the individual’s strengths in negotiating interactions with the environment, including its accessibility, accommodations and social attitudes. This model illustrates how some environments impede individual functioning by erecting barriers to full participation (Linton, 1998). Solutions include using universal design to create accessibility for everyone, allowing individuals with disabilities to make their own decisions, educating the public about disability issues and attitudes, and enforcing laws to ensure equal access and protection (Olkin, 1999b; Smart, 2001). In this model, a psychologist can facilitate a client’s positive disability identity and self-advocacy skills, or consult with others to ensure that the client has adequate accommodations, opportunities for participation, and a voice in decision making.

As practiced in forensic psychology and neuropsychology, the forensic model of disability centers on legal concepts, rather than individual experiences of disability. This model requires objective proof of impairment and disability to determine the honesty and motivation of individuals seeking recognition, benefits or compensation for disability. It has fostered a proliferation of psychological approaches to detect malingering, feigning, symptom exaggeration, and invalid or poor effort (Dersch, Polatin, Leeman, & Gatchel, 2005; Schultz, Crook, Fraser, & Joy, 2000; Schultz et al., 2007; Stowell, 2005).

The World Health Organization’s *International Classification of Functioning, Disability, and Health (ICF) Model of Disability* (WHO, Peterson, 2005; 2001) integrates disability’s medical and social dimensions and views disability as an interactive construct. An impairment’s functional limitations become disabling in the context of broader physical, social and attitudinal factors (Peterson, 2005; Schultz et al., 2007). Psychologists in various specialty areas are translating this model for psychological research and practice (Bruyère & Peterson, 2005; Bruyère, Van Looy, & Peterson, 2005; Reed et al., 2005).
Guideline 2: Psychologists strive to learn about federal and state laws that support and protect people with disabilities.

The goal of laws that protect the rights of individuals with disabilities is to ensure their freedom to fully participate in all aspects of society (Crawford, Jackson, & Godbey, 1991; Pullin, 2002). Three primary federal laws affect individuals with disabilities: Sections 503 and 504 of the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990; and the Individuals with Disabilities Education Act (IDEA) (1997).

Sections 503 and 504 of the Rehabilitation Act of 1973 (Public Law 93-122) mandate equal access to programs and services. Together, they prohibit disability-based discrimination by federally funded institutions. This law has increasingly been used in schools to provide services for children who do not qualify under IDEA. Sections 503 and 504 do not apply to non-federally funded institutions and do not provide administrative process for getting accommodations and other services and/or the due process available under IDEA (Rae, Fournier, & Roberts, 2001).

The ADA provides comprehensive civil rights protection to individuals with disabilities. Title I prohibits discrimination in employment on the basis of a disability for qualified individuals who, with or without a reasonable accommodation, may perform the essential functions of a job. Employers are expected to provide reasonable accommodations for people with disabilities (Bruyère & O'Keeffe, 1994). ADA’s Title II prohibits excluding a qualified individual with a disability, by reason of such disability, from participating in or securing the benefits of services, programs, or activities of a public entity (42 U.S.C § 12131 et seq.). This title includes all aspects of school programs, facilities, and services. Title III covers accessibility requirements for so-called “places of public accommodations”. Requirements include providing a wide variety of entities, services, and modifications so that people with disabilities have equal access to those environments (42 U.S.C § 12181-12189 et seq.). Title IV covers telephone and television access for people
with hearing and speech disabilities. It requires telecommunication companies to provide interstate and intrastate relay service 24 hours a day, 7 days a week to individuals who use telecommunication devices for the deaf (47 U.S.C. § 201 et seq.). Title V includes miscellaneous provisions, such as the recovery of legal fees for successful proceedings pursuant to the Act. It also prohibits coercing, threatening, or retaliating against people with disabilities or those attempting to aid people with disabilities in asserting their rights under the ADA (42 U.S.C 12201 et seq.).

The Individuals with Disabilities Education Act, enacted in 1975 (Public Law 94-142), and amended in 1997 and 2004, mandates that each student suspected of having a disability be assessed in all relevant areas, which may include health, vision, hearing, social, emotional, general intelligence, academic status, adaptive behavior, communication and motor skills. If a student is determined to be eligible for special education services, a team identifies his or her strengths and needs, writes an individual education plan (IEP), develops specially designed instruction, and establishes benchmarks to measure the student's academic and behavioral progress (National Council on Disability, 1996). Decisions are based on specific educational needs and performance on multiple measures.

State laws may provide more protection than federal laws for citizens with disabilities, but never less protection.

*Guideline 3: Psychologists strive to provide a barrier-free physical and communication environment in which clients with disabilities may access psychological services.*

An accessible office facilitates service delivery for clients with disabilities. As an alternative, a psychologist may conduct sessions in a mutually convenient accessible location, or refer the client to an appropriate psychologist with similar or greater qualifications.
Accessibility encompasses the following:

a) **Clients with disabilities need accessible transportation services in order to get to a psychologist’s office.** An office location with nearby accessible public transportation enhances access to services for clients with disabilities. It is also helpful to be aware of other accessible transportation options, such as wheelchair-accessible van services.

b) **Physical accessibility of the building allows a client with a disability to enter and move about within service delivery areas.** Parking lots need designated parking; pathways to buildings need curb cuts; external and internal doorways should be wide enough for wheelchair access; doors need automatic openers or easily manipulated handles; bathrooms should be accessible; ramps and elevators should be available as needed; lighting should be adequate for people who rely on vision for orientation or communication; and there should be barrier-free access to safety exits ("ADA Accessibility Guidelines," 2005; McClain, 2000; Olkin, 1999b).

c) **Communication access also accommodates various disabilities.** Clients with communication disabilities may require appropriate use of specific methods or technology to facilitate psychological service delivery. Clients with speech disabilities may communicate with alternative or augmentative communication such as speech boards, speech synthesizers or computers. Clients with hearing loss and/or speech disabilities may call or be called via telephone relay services, internet relay services, and video relay services. Each service uses operators sworn to confidentiality to facilitate communication (Federal Communications Commission, 2006). Other clients may prefer to use cell phone text messaging and secure electronic mail, or secure videophone or teletype equipment. Sign language interpreters or computers may be used for interpersonal communication during sessions. Clients with cognitive disabilities or various linguistic needs may require simplified, easy-to-understand documents, such as office paperwork (Wehmeyer, Smith, &
Clients with visual disabilities may need documents in large print, as text files on disk, or in Braille (Lighthouse International, 2006; Olkin, 1999b).

*d) Clients with disabilities need access to informed consent.* Psychologists are sensitive not only to confidentiality but also to issues of informed consent to services. The client with a disability must provide consent in the manner prescribed for all clients by Standard 9.03 of the APA Ethics Code (2002). This Standard permits exceptions, including group testing or other routine organizational activities, and the evaluation of decisional capacity (e.g. severe dementia). Special considerations include communication barriers and the use of interpreters discussed in Guideline #5, using consent language that the client can reasonably understand, and respectfully evaluating the need for consent by legal guardians (Fisher, 2003).

Guideline 4: Psychologists strive to examine their beliefs, misconceptions, biases, and emotional reactions toward disability and determine how these might influence their work.

Research suggests psychologists and other mental health professionals often lack sufficient knowledge of disability issues and have little experience working with clients who have disabilities (Strike et al., 2004). With little understanding of disability experience, psychologists may feel anxious, repulsed, fearful, and vulnerable when working with clients who have disabilities (Olkin, 1999a). Lack of experience may lead to erroneous assumptions about clients with disabilities.

One such assumption is the “spread” effect in which a psychologist might assume that any client with a disability must have certain related characteristics (Livneh, 1982; Olkin, 1999b; Wright, 1983). For example, a psychologist might believe a woman with severe arthritis must be depressed. A psychologist may also attribute a characteristic to having a disability, such as assuming that a woman has strong career ambitions to compensate for having a limb loss.
Research suggests psychologists tend to believe problems experienced by clients with intellectual disabilities are attributable to their disability as opposed to psychological conditions, such as depression (Mason & Scior, 2004; Nezu & Nezu, 1994; Reiss, Levitan, & Szyszko, 1982). This is an example of over-emphasizing or mistakenly focusing on a client’s disability while ignoring important aspects of her life, such as life events, capabilities and strengths, and other issues related to the client’s presenting problems (Jopp & Keys, 2001; Kemp & Mallinckrodt, 1996; Mason, 2007; Reiss et al., 1982; White, Nichols, Cook, & Spengler, 1995). Conversely, psychologists may under-emphasize disability-related concerns, or even assume clients use their disabilities as an excuse. For example, a couples therapist might fail to ask about a client’s physical needs before suggesting that she is using her disability-related concerns as an excuse not to move into her significant other’s home.

Lack of familiarity with disability may influence how a psychologist perceives and works with the emotions that clients with disabilities express. Individuals with disabilities have often experienced lack of accommodations, personal slights, insensitive behavior, and discrimination. They may express feelings of sadness, anger, and frustration about their disability experiences. A psychologist may perceive such expressions as a sign that a client has not adjusted to a disability, rather than as an emotional response to painful experiences (Olkin, 1999a; Vash & Crewe, 2004; Wilson, 2003).

Guideline 16 suggests ways for psychologists to examine their attitudes and beliefs about disability. Guideline 22 offers more suggestions about disability experience and training in disability-related issues.

Guideline 5: Psychologists strive to use appropriate language and respectful behavior toward individuals with disabilities.
Principle E of the APA’s Ethical Principles (2002) respects the dignity and worth of all people, and supports the use of disability-sensitive language. APA’s Publication Manual (2001) cautions against using language which equates individuals with their conditions (e.g. the disabled or the psychotic). Such language may bias diagnostic and intervention processes (Simeonsson & Scarborough, 2001). Also, Standard 9.11 of the Standards for Educational and Psychological Testing (1999) emphasizes the importance of respecting language preference and competency.

Language may reveal our attitudes toward people with disabilities (Hauser, Maxwell-McCaw, Leigh, & Gutman, 2000). Excessively positive language (e.g., “heroic” or “despite his disability”) or excessively negative language (e.g., “disgusting”) regarding people with disabilities focuses on stereotypes, rather than individuals (Katz, Hass, & Bailey, 1988). People-first language (e.g., a woman with multiple sclerosis; a student who is depressed) is preferred to disability-first language (e.g. a deaf actress). Avoid stereotypical or derogatory phrases that imply deficiency or inadequacy such as “deaf and dumb” since a person with a hearing impairment is perfectly capable of intelligent communication (Gill et al., 2003; Khubchandani, 2001; Olkin, 2002). Appropriate language describes an individual’s positive attributes and does not imply that disability is a deficiency.

While we assume that communication is mostly verbal (i.e. spoken, signed and written language), approximately 70-80% of communication is nonverbal, including facial and body language, personal mannerisms, and style — anything that adds meaning to a message (Mehrabian, 1968a, 1968b). As such, it is a powerful tool for shaping the context of the client-psychologist dialogue. A psychologist who responds appropriately validates the client and minimizes possible bias and misperception about the client’s disability (Khubchandani, 2001; Kosciulek, 1999; Olkin, 1999b). Examples of appropriate responses include sustaining eye contact with a client who uses a sign language interpreter to communicate, rather than...
focusing on the interpreter. Refrain from staring at a client’s physical differences. You may ask if a client who has a disability needs assistance with a task, but do not “help” without permission — and ask for specific instructions on how to be most helpful.

The way that a client with a disability speaks or moves his body may result in misunderstandings (Leigh & Brice, 2003; Wright, 1989). A psychologist might perceive an articulate person as intelligent, and inaccurately judge a client whose speech is labored as less intelligible. Facial expressions may be involuntary or can have multiple meanings, reflecting not only possible underlying psychological issues, but often responses to issues such as chronic pain or memory problems. Sign language users use facial expressions to convey many nuances of meaning. Body language may reflect disability-related needs, such as frequently changing position in a wheelchair to prevent pressure sores, or adjusting position in response to lighting or temperature changes. Verbal and non-verbal messages may conflict (Wright, 1987) and a clinician can easily misinterpret the amount or types of presented emotion and undervalue or ignore a client’s input.

With patience, psychologists can enhance and accommodate their clients’ communication needs in several ways. This accommodation requires acknowledging that it may take extra time to effectively communicate with a client who has a disability (Leigh & Brice, 2003). A sensitive psychologist will adjust his or her listening to the client’s rate of speech. A client with a visual disability may need specific descriptions to help orient himself to the immediate environment. It helps to articulate words clearly and pause between statements for clients who have language processing disabilities. A psychologist can first say the name of a client with an attention disorder, make eye contact with the client, and then proceed with the session. Some clients may use visual communication systems, speech synthesizers, other specialized approaches, or sign language interpreters (Olkin, 1999b). The best way to facilitate clinical work is to ask the client how she prefers to communicate and to consult experts for additional information.
Guideline 6: Psychologists strive to understand both the common experiences shared by persons with disabilities, and the factors that influence an individual’s personal disability experience.

The presence of a disability reveals little about a person (Dunn & Dougherty, 2005; Olkin, 1999b).Individuals with disabilities have unique life histories in addition to their own disability experiences, and experiences they share with other people who have disabilities.

Hassles are often part of disability experience. A person who uses a wheelchair must get in and out of her car. A student with a visual impairment must read a textbook. A person with a brain injury must juggle multiple medical appointments. These added challenges can be frustrating, exhausting and time-consuming.

Individuals with disabilities are often more socially isolated than people without disabilities (Livneh & Antonak, 1997; Nosek, Howland, Rintala, Young, & Chanpong, 2001). They experience discrimination and stigmatization, which may contribute to feeling ostracized and different. Limited contact with other people who have disabilities in their families, at school or on the job exacerbates this experience of being different from others.

The dimensions of an individual’s disability may influence personal experiences. For example, individuals with visible disabilities are more likely to feel marginalized. The stares and questions of others often make them feel as if they are on display (Olkin, 1999b). Individuals with invisible disabilities (e.g. learning disabilities, mental health disabilities) have difficulty convincing others that they have a disability (Smart, 2001; Taylor & Epstein, 1999). Other aspects of disability that may affect a person’s disability experience include functional capacities, energy levels, pain, age of onset, and whether the disability is static, episodic, or progressive.
People with disabilities also experience the same things that affects everyone else’s life, such as their family of origin, their community, their schooling, their friends, their adult significant others and co-workers. Such common influences may shape a person’s individual disability experience. For instance, different parents of children with disabilities may impart very different messages about what it means to have a disability. One child may be protected from risk, while another is expected to tackle challenges. Similarly, a person with an intellectual disability who lives in a community that includes people with disabilities in educational, recreational, and vocational opportunities will likely have more self esteem than a person without such opportunities.

Finally, each person with a disability has his or her own unique disability identity. A person with an apparent impairment may not feel that she has a disability. Many individuals with deafness believe they have a language barrier, not a disability. Other people with disabilities may see themselves as members of a disability community and culture that shares common experiences (e.g., Linton, 1998; Longmore, 1995).

Guideline 7: Psychologists strive to recognize social and cultural diversity in the lives of person with disabilities.

An individual’s disability experience occurs within the social and cultural context of that person’s life. To effectively work with clients who have disabilities, psychologists may need to consider how a client’s disability-related issues interact with any other diversity concerns. Other APA Guidelines² pertain to working with clients from diverse cultural and

² The following APA Guidelines may enhance a psychologist’s competency in working with persons with disabilities from diverse social and cultural backgrounds: Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients (APA, 2000); Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists (APA, 2003); Guidelines for Psychological Practice with Girls and Women (APA, 2007); and Guidelines for Psychological Practice with Older Adults (APA, 2004).
social backgrounds. Psychologists are encouraged to read these in order to work more effectively with clients from diverse backgrounds who also have disabilities.

People of color (except those of Asian/Pacific Island descent), women, and older adults are more likely to have a disability than their counterparts (U.S. Census Bureau, 2000). Higher rates of disability in people of color are related to several factors, including poverty, lack of education and employment opportunities, violence, limited access to healthcare, and personal behaviors (Flack et al., 1995). Older adults are more likely to experience disability since the incidence of disability increases with age (U.S. Census Bureau, 2000).

Different cultural, religious, minority groups, and subcultures may attribute different causes and meanings to disability. Some believe disability is a punishment or fate. Disability-related concepts such as independent living and autonomy may vary or not apply among different groups (Bryan, 2007; Lomay & Hinkebein, 2006; Uswatte & Elliott, 1997).

Women with disabilities report experiencing significant levels of depression and low self-esteem (Hughes, Nosek, & Robinson-Whelen, 2007; Niemeier, 2008; Nosek, Howland et al., 2001), both of which are associated with social isolation, poorer quality of intimate relationships, pain, higher risk of abuse, and higher rates of unemployment (Nosek et al., 2001). Men with disabilities may experience psychological distress from threats to sexual identity and masculinity and concerns about self-reliance, independence, and employment (Marini, 2001).

Individuals who have disabilities and who are also gay, lesbian, bisexual, or transgender face a unique challenge. The larger society, and possibly their own families, are more likely to ostracize them (Olkin, 1999b).
Location also affects the experience of disability. For example, rural Americans lack access to the wide range of services and supports available in urban areas (Seekins, 1995; Stamm et al., 2003). They must spend time and money traveling to access critical services. Psychologists working in rural areas may serve clients in a wide variety of geographical settings and can accommodate them by allowing for necessary travel.

Many people with disabilities also live in poverty (Lustig & Strauser, 2007). Disability and poverty are reciprocal — disability increases the risk of poverty, and the living conditions and limited access to health care associated with poverty increases the risk of disability. People with disabilities, who struggle with poverty, have lower quality of life because they are unable to pay for services, and have limited access to assistive technology and home modifications.

*Guideline 8: Psychologists strive to learn how attitudes and misconceptions, the social environment, and particular nature of a person’s disability influence development across the lifespan.*

Like most people, individuals with disabilities strive to achieve age-appropriate developmental tasks and milestones, such as forming friendships with peers, pursuing an education, developing a cohesive identity, becoming sexual and establishing intimate relationships, getting a job, conceiving and raising children, and growing old. For individuals with disabilities, the ability to achieve developmental goals often depends less on the nature of their disabilities than on their personal relationships with family, significant others and friends; and systemic interactions with their schools, employers, healthcare providers and communities (Goodley & Lawthom, 2006; Olkin, 1999b; Reeve, 2000; Woolfson, 2004). For example, to successfully transition into adulthood, a high school student with a learning disability needs an encouraging and supportive family, and a school that provides good academic and vocational preparation. To successfully negotiate
aging, a woman with a spinal cord injury may need available, accessible community supports, personal assistance services, and assistive technology. Societal attitudes and biases may also restrict an individual’s opportunities for typical development (Murray, 2006; Woolfson, 2004). For example, a professional who predicts that a teenager with a mild intellectual disability cannot work and will need constant supervision may convince her parents to restrict her opportunities for adult development.

Age of disability onset also links to the relationship between disability and development and can affect how psychologists approach assessment and intervention. Learning and intellectual disabilities, pervasive developmental disorder, and cerebral palsy are usually diagnosed early and have life-long effects. Individuals with later-onset disabilities, such as multiple sclerosis, schizophrenia, and traumatic brain injury may need psychological support as they work through their cognitive and emotional responses to current and future developmental challenges (Olkin, 1999b; Smart, 2001).

The course of a disability may also affect an individual’s development (Olkin, 1999b; Vash & Crewe, 2004). Some disabilities essentially do not change (e.g., intellectual disability), some are often episodic (e.g., schizophrenia), and others are progressive (e.g., amyotrophic lateral sclerosis). The expected course of a client’s disability will often affect evaluations and interventions. For example, a boy with muscular dystrophy and his family may need to address end of life issues.

**Guideline 9: Psychologists strive to recognize that families of individuals with disabilities have strengths and challenges.**

Families of individuals with disabilities often face additional challenges and stresses. Families spend extra time helping a member with self-care needs, researching a family member’s disability, keeping frequent medical and therapy appointments, and often bear extra financial burdens (Ainbinder et al., 1998; Dobson & Middleton, 1998; Powers,
1993; Singer & Powers, 1993; Turnbull & Turnbull, 1991). Along with these stressors, family members may feel frustrated, angry, confused, exhausted and sad (Rolland & Walsh, 2006).

Despite these issues most families of people with disabilities are resilient. They meet these challenges and enjoy a quality family life by realigning their priorities, balancing the needs of all family members, and by deciding what is important in life (Goodley & Tregaskis, 2006; Wilgosh, Nota, Scorgie, & Soresi, 2004; Wilgosh & Scorgie, 2006). For many families, disability is a meaningful growth experience. Family members recognize their own personal strengths, such as patience and problem solving skills, while experiencing greater empathy for and understanding of others (Goodley & Tregaskis, 2006; Scorgie, Wilgosh, & McDonald, 1996; Scorgie, Wilgosh, & Sobsey, 2004).

Adults with disabilities may be spouses, parents, siblings, aunts, uncles, significant others, and grandparents. However, societal biases and misconceptions often limit their full participation in family life. It is a myth that adults with disabilities usually do not have intimate relationships or marry. While some adults with disabilities have competency and guardianship issues, psychologists are encouraged to recognize that most adults with disabilities have a right to sexual intimacy, marriage and a family (O’Toole & Doe, 2002; Olkin, 1999b). For example, adults with physical and sensory disabilities can and do effectively parent children (Buck & Hohmann, 1981; Olkin, Abrams, Preston, & Kirshbaum, 2006).

Disability may not be a salient factor when the family of a person with a disability seeks psychological services. However, psychologists are encouraged, when appropriate, to include families in assessments and interventions to help manage stress, develop resiliency, enhance quality of family life, and resolve feelings about disability (Bailey Jr. et al., 2006; Ehrmann & Herbert, 2005; Power & Dell Orto, 2004; Scorgie et al., 2004; Turnbull & Turnbull, 2001; Wilgosh et al., 2004). Family reactions to disability may not
necessarily reflect mourning and loss, but instead may be related to uncertainty about the present and future. For example, parents of an infant with a disability may not be mourning the loss of an idealized child. Their anger, fear and confusion may stem from their concern about their child’s future and how to afford expensive medical care.

As a practical response, psychologists might help families find information and resources. Teaching self-advocacy skills to families may also empower them. For example, a school psychologist might help the parents of a child with dyslexia advocate for the child’s educational needs.

Guideline 10: Psychologists strive to recognize that people with disabilities are at increased risk for abuse and address abuse-related situations appropriately.

People with disabilities are often vulnerable to violence and abuse (Hassouneh-Phillips & Curry, 2002; Horner-Johnson & Drum, 2006; Hughes, 2005; Sullivan & Knutson, 1998). Compared to youth without disabilities, children and adolescents with disabilities may be three to ten times more likely to be abused or neglected (Sullivan & Knutson, 2000), particularly those with behavior disorders, intellectual disabilities, communication disorders, or multiple disabilities (Sullivan & Knutson, 1998). Women with disabilities also are at elevated risk of abuse (Brownridge, 2006; Martin, Serte-Alvarez, Kepper, Meracco, & Prickers, 2006; Smith, 2008), and they experience abuse for longer durations than women without disabilities (Nosek, Foley, Hughes, & Howland, 2001). Although men with disabilities experience similar types of abuse, society often fails to recognize this (Saxton, McNeff, Powers, Curry, & Limont, 2006). People with disabilities are at risk for abuse because they are perceived to be powerless, and may be physically helpless, socially isolated, emotionally deprived, and sexually naïve. Perpetrators have less risk of being discovered, and people with disabilities are less likely to be believed if they do report abuse or neglect (Andrews & Veronen, 1993; Nosek, Foley et al., 2001; Sobsey, 1994).
In addition to emotional, physical and sexual abuse, people with disabilities are vulnerable to disability-specific abuse. Violence against individuals with disabilities can include the withholding or excessive administration of medications, involuntary confinement, withholding or dismantling assistive equipment (e.g. wheelchairs), and withholding personal assistance for essential daily living activities such as eating and personal hygiene (Hughes, 2005; Nosek et al, 2001; Saxton et al., 2001). In institutional or community settings, individuals with disabilities who use personal assistance services experience a high incidence of neglect, verbal and/or physical abuse, and financial exploitation at the hands of their assistants (Oktay & Tompkins, 2004; Powers, Curry, & Oswwald, 2002).

Abuse and neglect may be the initial cause of a disability, may exacerbate an existing disability, and may cause depression and other secondary conditions (Kendall-Tackett, Lyon, Taliaferro, & Little, 2005; Mitchell & Buchele-Ash, 2000; Olkin et al., 2006). When clients with disabilities report abuse and neglect, Nosek, Hughes, & Taylor (2004) suggest that the psychologists:

a) know the signs, symptoms, and dynamics of disability-related violence, including the unique areas of vulnerability noted above;
b) screen for abuse and neglect, and intervene appropriately;
c) document the history of abuse and neglect;
d) discuss safety planning with clients, such as having a safe retreat, back-up personal care assistance, and social supports;
e) maintain current contact information for accessible local domestic violence/sexual assault programs and disability service providers (e.g. centers for independent living); and,
f) learn state mandatory reporting requirements for violence against people with disabilities, elders, and dependent adults, and involve the victim throughout the reporting process.

Guideline 11: Psychologists strive to learn about technological opportunities and challenges in the lives of people with disabilities.

Assistive technology is defined as equipment, products, or systems that improve the functional capabilities of people with disabilities. Assistive technology includes ventilators that help people breathe; vans with ramps or lifts for transporting people who use manual and power wheelchairs and scooters; adaptive eating utensils; hearing devices and text pagers; reading technology (e.g. JAWS computer screen-reading software; the Kurzweil Reader which converts text to speech) for people with visual or learning disabilities; and programs to simplify written language for individuals with neurodevelopmental disabilities (Wehmeyer, 2006; Wehmeyer, Smith, & Davies, 2005). Computers with touch and/or voice activated programs and assistive devices allow users with communication disabilities to use a laser wand (usually attached to the person’s head) to choose symbols or spell words, construct sentences, and “speak” with a synthesized voice (Beukelman & Mirenda, 2005; Wehmeyer et al., 2005).

A psychologist needs to understand that this technology is a mixed blessing. In addition to the opportunities it offers people with disabilities, it imposes the responsibilities of researching new technologies and assistive devices; learning to use new technology (Pell, Gillies, & Carss, 1999); and funding and maintaining equipment (NTFTD Report, 2004). People may be frustrated when unavailable, unaffordable, or inaccessible technology (e.g. some web sites) limits their opportunities (Flowers, Bray, & Algozzine, 1999). While assistive technology may increase a person’s independence, it may also pose a social barrier that makes the user seem too different or somehow deficient (Lupton
While one person eagerly uses technology to attain objectives or enhance his life, another may find it overwhelming. Although not all people with disabilities and their families values, are interested in, or are enthusiastic about assistive technology, understanding how it can affect a user’s self-image, self-efficacy, and coping and adaptation skills is important.

Finally, keeping up with the rapid advances in technology is difficult. A psychologist often needs to be prepared to refer clients with disabilities to appropriate local assistive technology service providers.

**Testing and Assessment**

*Guideline 12: In assessing persons with disabilities, psychologists strive to consider disability as a dimension of diversity together with other individual and contextual dimensions.*

When conducting psychological assessments, it is essential to consider the interaction between the individual with a disability and his or her environment. The dimensions of this interaction include how the individual functions over time, in varied situations, and in response to environmental demands (Bruyère & Peterson, 2005; Bruyère et al., 2005; Peterson, 2005; Radnitz, Bockian, & Moran, 2000; Reed et al., 2005; Scherer, 1998; Simeonsson & Rosenthal, 2001). Considering the central role of contexts in assessing a person’s psychological functioning is consistent with the ICF’s integrative model of disability (WHO, 2001). For example, understanding co-workers’ attitudes, family members’ responses, classroom design elements, or the effect of school or work accommodations is important in assessing individuals with disabilities (Bruyère & Peterson, 2005; Bruyère et al., 2005; Hurst, 2003 & Szymanski, 2000 (both as cited in Reed, et al 2005); Peterson, 2005; Reed et al., 2005).
As a complement to the contextual approach in clinical settings, a psychologist may also assess the relationship between an individual’s capacities and limitations. Some psychologists view cognition, functional status and life history as “core capacities” (Scherer, 1998). Coping and adaptation are additional capacities (Heinemann, 1995 as cited in Cushman & Scherer, 1995). Other factors that might be assessed include positive psychology concepts such as seeking meaning and positive growth (Dunn, 1996; Elliott, Kurylo, & Rivera, 2002; Heckhausen & Schulz, 1995; Kennedy et al., 2000; Tennen & Affleck, 2002) and optimism and self-determination (Marini & Chacon, 2007). Conducting a personality assessment can help a psychologist understand the meaning of disability in a client’s life and the way in which the client is likely to experience intervention.

The established methods and instruments used in neuropsychology and rehabilitation, forensic, and educational psychologies have traditionally assessed the limitations of individuals with disabilities, rather than their strengths. In all specialty areas, it is important for psychologists to assess a person with a disability in context, rather than the disability alone.

Guideline 13: Depending on the context and goals of assessment, psychologists strive to apply the assessment approach that is most psychometrically sound, fair, comprehensive, and appropriate for clients with disabilities.

However, the *Standards for Educational and Psychological Testing* (1999, hereafter referred to as the Standards) is the document that is most specific in describing the appropriate uses of testing. The *Standards* make the distinction that, in applied settings, psychologists strive not just to test individuals, but to assess the individuals: “The label test is ordinarily reserved for instruments on which responses are evaluated for their correctness or quality” (p. 3). “Assessment is a broader term, commonly referring to a process that integrates test information with information from other sources” (p. 3).

Psychological assessment involves solving problems or answering questions (Vanderploeg, 2000) and, in addition to reviewing test results, may incorporate multiple data collection methods: behavioral observation, an interview with client(s), collateral interviews, and reviews of case records (Vanderploeg, 2000).

Since working with clients who have disabilities requires specialized knowledge and skills, both the 1985 and 1999 versions of the *Standards* included chapters on testing individuals with disabilities. Determining whether a measure is appropriate for a client with a disability requires reviewing its validation efforts. The relevant data should support the measure’s use with people who have specific disabilities, just as they may support its use for the entire population (Standard 7.1). Moreover, measures should be positively evaluated as useful with clients who have these disabilities (Geisinger, 1998).

Measures should either include individuals with relevant disabilities in their norm groups or have separate norms. For example, some depression scales have been developed, normed, and validated on populations that do not include individuals with specific disabilities. These scales measure perceived health, pain and fatigue. When applied to an individual with a disability, the results may indicate he is depressed, which may be an inaccurate interpretation.
Standardized assessment instruments may lack appropriate norms and/or may not accommodate clients with specific disabilities. In that case, the psychologist attempts to find instruments that maximize the collection of valid information. To judge whether it is appropriate to employ a measure used with the general population for clients with specific disabilities, read the manual or contact the test’s publisher for more information (Geisinger, 1998).

**Guideline 14: Psychologists strive to determine whether accommodations are appropriate for clients to yield a valid test score.**

A testing accommodation is a change in a test format or content, or some aspect of test administration which makes the test accessible to individuals who might otherwise be unable to complete the measure. Making accommodations will help a psychologist test and assess clients with varying levels of ability. Scientists have carefully scrutinized the validity of accommodation measures in certain educational settings (Koenig & Bachman, 2004; Sireci, Scarpati, & Li, 2005; Willingham, Ragosta, Bennett, Rock, & Powers, 1988). It is expected that for many kinds of tests an accommodated measure would yield more valid results than the same measure without such accommodations. Still, validation research is always appropriate. Some testing professionals distinguish between accommodations and modifications. The former change in test administrative procedures is not believed to affect the construct being measured whereas modifications in testing may impact the valid measurement of the construct. For some tests, the validity of unaccommodated results may be lower than accommodated results if the person with disability requires accommodations and they can be provided without fundamentally altering what is tested. For example, a student with a visual disability using a large-print format reading test may need additional time to accommodate turning pages (i.e., to refer between the reading selection and the test questions). Without extra time in addition to the
large-print format, the student’s score is likely to be less valid than if the appropriate time were granted.

The 1999 *Standards* identified a variety of ways in which tests might be modified for administration to individuals with disabilities. These accommodations (or modifications) include (1) altering presentation format, (2) altering response format, (3) altering timing, (4) altering the test setting, (5) using only portions of the test, and (6) using substitute tests or alternative assessments. Changing the presentation format is a common accommodation for many individuals with disabilities. A paper-and-pencil test may be administered in Braille or audiotape formats, or computerized for use with a screen reader. Permitting test takers with disabilities to use alternative response formats allows them to record their answers in the most accurate way. Some test takers may also require assistance from an aide. To assure their continued validity, tests justified with the general population on the basis of criterion-related validity may require separate validity studies of test takers with disabilities. Although altering the time allowed to complete a test is a controversial modification, especially for intellectual ability or academic achievement tests, researchers have found it is often a valid accommodation, especially for academic achievement tests. Allowing additional time is a primary accommodation (e.g., for individuals with learning disabilities), but sometimes it relates to another accommodation. For example, it takes more time to read Braille or large-print format tests than standard text tests. Both Braille and large-print documents have many more pages to turn. An individual with an extreme movement disorder may have great difficulty filling in bubbles on an answer sheet; an alternative assessment tool may be appropriate. It is critical to continue to identify ways in which individuals with disabilities can be tested appropriately, either by using accommodations or employing different but similarly valid measures. It is
possible to use a replacement or alternative measure, if it has comparable validity and is less influenced by the individual’s disability.

To enhance valid decision making, psychologists need to know whether a test publisher approves of certain accommodations for individuals with specific disabilities. The accommodations must have been evaluated with such individuals (Standard 10.3), and found to represent the construct underlying the test for members of this population (Standard 10.1). Test administration modifications must be carefully studied (Standard 10.4). In order to report a valid and accurate assessment, a professional interpreting the test score of an individual who received an accommodation may need additional knowledge about the individual’s disability, as well as about the construct measured by the test (see Standard 10.2). It is also necessary to determine whether it is appropriate to use the test’s general norms or any existing specialized norms (Standard 10.9). It may be necessary to assess the extent of the individual’s disability to determine its comparability to that in specific specialized or general norm tables, and to determine whether the individual is similar to other participants in any validity studies. Avoid tests with documented biases or problems when used with individuals with disabilities.

Flagging is a controversial practice wherein an asterisk identifies scores earned by individuals taking an accommodated test. It is most typically, but not exclusively, used in making academic admissions decisions. The Rehabilitation Act of 1973 permits flagging, although its appropriateness under other laws is questionable. In some cases, flagging can imply that the score misrepresents the test-taker’s competence. Individuals with disabilities and disability advocacy groups believe that such asterisks are “scarlet letters” that negatively influence admissions and other decisions.

*Guideline 15: Consistent with the goals of the assessment and disability-related barriers to assessment, psychologists in clinical settings strive to appropriately balance quantitative,*
qualitative and ecological perspectives, and articulate both the strengths and limitations of assessment.

To maximize assessment validity, psychologists are encouraged to apply integrative multi-method assessments rather than rely solely on test scores. The literature identifies three approaches to the psychological assessment of individuals with disabilities: quantitative, qualitative, and ecological (Simeonsson & Rosenthal, 2001; Parker & Schaller, as cited in Szymanski & Parker, 2003). Guidelines 13 and 14 discuss quantitative assessment. Qualitative assessment focuses on observation and interview, and is idiographic and holistic. Few qualitative measures have been properly validated. Qualitative measures may be especially useful in specific applications (e.g. vocational assessment) or when no psychometrically appropriate measures are available for a client whose severe or complex disabilities are a barrier to standardized assessment. Clients actively collaborate with the psychologist in this approach (Healy, 1990 as cited in Parker & Schaller, in Szymanski & Parker, 2003).

Some scholars subsume the ecological approach under the qualitative assessment approach. The ecological approach assesses behavior in context. It is an idiographic approach which unobtrusively observes a person with a disability in natural settings and avoids norm-referenced interpretations. It is particularly applicable to children with disabilities, adults with multiple barriers to other forms of assessment, and specific service settings, such as vocational settings (Simeonsson & Boyles, 2001 as cited in Simeonsson & Rosenthal). The most commonly used qualitative assessment approaches use multiple sources of data including clinical interview, behavioral observation and functional assessment.

In assessing a client with a disability in a clinical setting, a psychologist can conduct an integrated, semi-structured interview about the client’s relevant disability-
related issues, their relative importance among various personal concerns, and how they interact with other psychological issues (Mohr & Beutler, 2003). When appropriate in the context of the assessment’s goals, the psychologist may ask about the client’s type and origin of disability; his or her perception of disability-related strengths and limitations; the functional impact of the client’s disability; the reactions of others to the client’s disability; required aids, accommodations, treatments and medications; and necessary lifestyle modifications (Olkin, 1999b; Vane & Motta, 1987).

It is important for the psychologist to watch not only external manifestations of the client’s disability, such as behavioral mannerisms, speech difficulties, and medical symptoms or physical anomalies, but also a wide range of other functional domains (e.g., level of arousal, language, psychomotor and motor functions, cooperation, interpersonal skills, cognition, mood, affect and emotional state, frustration tolerance, coping and insight (Vanderploeg, 2000). When the client uses assistive technology and accommodations, it is advisable to incorporate them into the behavioral observation to avoid capturing unaccommodated disability rather than the target behavior (Kirshbaum & Olkin, 2002; Kirshbaum, 1986).

Functional assessment measures how a person interacts with the environment and focuses on various domains of real-life skills that enable the person to independently engage in his/her environment (Halpern & Fuhrer, 1984 as cited in Crewe & Dijkers Chapter, in Bedell, 1994; NASP, 2000; Shriver, Anderson, & Proctor, 2001). It is particularly useful for clients who have disabilities, including those with multiple barriers to assessment. Functional assessment observes the client’s living, working, social, and/or learning environments and portrays the extent of the client’s adaptive behavior (Yoman & Edelstein, 1994). This assessment focuses on social behavior, activities of daily living, school or work behavior, communication, motor skills and functional academic skills.
Subsequently, both behavior and environment may become targets for intervention (Bruyère & Peterson, 2005; Bruyère et al., 2005; Gaylord-Ross & Browder, 1991; McComas, Hoch, & Mace, 2000 as cited in Shapiro & Kratchowill 2000; Peterson, 2005; Reed et al., 2005; Yoman & Edelstein, 1994).

While recognizing that their competence in assessing clients with disabilities may be limited, psychologists are encouraged to consider a multidisciplinary perspective. They can learn from their peers in other professional domains, including special education and clinical, occupational and community rehabilitation. For example, functional assessment of work-related communication and social skills of a person with severe brain injury may require a team comprising a psychologist or a neuropsychologist, a speech and language therapist, an occupational therapist, and others.

**Guideline 16: Psychologists in clinical settings strive to maximize fairness and relevance in interpreting assessment data of clients who have disabilities by applying approaches which reduce potential bias and balance and integrate data from multiple sources.**

Psychologists attempt to recognize any personal conceptions of and reactions to disability that may bias their interpretation of assessment data. Involving clients in clinical settings within a feedback loop (Farley, Bolton, & Parkerson, 1992; Finn & Tonsager, 1997) and using multiple independent information sources (Holzbauer & Berven, 1999; Vanderploeg, 2000; Vane & Motta, as cited in Van Hasselt & Hersen, 1999) may help to safeguard against bias-related problems.

The literature on fairness in psychological assessment suggests a number of strategies for removing or minimizing bias. These strategies include:

a) delaying professional judgment and decision until after rather than during an evaluation (Sandoval, Frisby, Geisinger, Scheuneman, & Grenier, 1998)
b) identifying personal preconceptions about persons with disabilities (Sandoval et al., 1998);

c) examining integrative primary and competing hypotheses regarding client issues and validating them using both confirmatory and disconfirmatory assessment (Sandoval et al., 1998; Ziskin & Faust, 1988);

d) developing complex schemas or conceptions of clients with disabilities based on the pertinent literature and individual experience (Elliott & Umlauf, 1995; Groth-Marnat, 2003; Sandoval et al., 1998); and

e) specifically addressing both strengths and weaknesses in functioning and retaining focus on the referral question (Schultz & Stewart, 2008).

Overall, psychologists strive to balance the consideration of social, clinical and psychometric disability-related issues with other intra-individual factors (such as sociodemographic background, motivation, strengths, resources, or coping skills) and environmental factors such as attitudes and reactions of others, context of assessment and various societal systems (Mackelprang & Salsgiver, 1999; Olkin, 1999b). Particular care in this regard needs to be exercised by psychologists performing assessments in high stakes, potentially contentious contexts, such as medico-legal assessments for entitlement to disability benefits that utilize special methods for evaluation of effort. Psychologists performing evaluations in this context are also encouraged to consult the Specialty Guidelines for Forensic Psychologists (APA, 1991).

Interventions

Guideline 17: Psychologists strive to recognize that there is a wide range of individual response to disability, and collaborate with their clients who have disabilities, and when appropriate, with their clients’ families to plan, develop, and implement psychological interventions.
In working with clients who have disabilities, a psychologist does not automatically assume that certain treatment modalities, interventions, and theoretical orientations are appropriate or inappropriate according to the individual’s type of disability. For example, a psychologist would not assume that a client with intellectual disability could not benefit from individual psychotherapy (Butz, Bowling, & Bliss, 2000; Mason, 2007; Nezu & Nezu, 1994). Critical aspects of psychological interventions include establishing a secure working relationship, understanding the client’s experiences, determining the client’s treatment needs, and collaborating with the client to formulate a plan. A client’s disability may make this process more complex.

Disability issues may or may not relate to why a person with a disability seeks psychological services. Disability concerns may be related to other issues, such as relationship problems (Blotzer & Ruth, 1995; Olkin, 1999b; Wilson, 2003). When formulating an intervention plan, a psychologist is encouraged to ask clients about their disability experiences. How disability-related concerns relate to the presenting problem will emerge as the psychologist learns about the clients’ life experiences.

When a client’s presenting concerns are disability-related, a psychologist recognizes that individuals respond to disability in varied ways. Clinical lore suggests that a person with a disability works through a sequence of feelings (e.g. shock, depression, and anger) and defenses (e.g. bargaining and denial) before psychologically adjusting to and accepting the disability (Livneh, 1986; Smart, 2001). Overall, there is little empirical support for the usefulness of such models in describing how individuals respond to disability (Elliott & Frank, 1986; Parker, Schaller, & Hansmann, 2003; Trieschmann, 1988). Some individuals may not experience emotions prescribed by the stage models of adaptation to disability. Others may experience strong emotional reactions, but not in a linear sequence. Some individuals may experience an emotion, work through it, and then return to it at a later time (Smart, 2001). Life circumstances (e.g., social support, income level), personality
characteristics (e.g., optimism, hope or coping skills), and the interaction between disability and environment (e.g., the ability to return to work) likely impact the person's response to disability much more than working through “stages” (Dunn, 1996; Elliott et al., 2002; Heckhausen & Schulz, 1995; Kennedy et al., 2000; Kortte & Wegener, 2004).

*Guideline 18: Psychologists strive to be aware of the therapeutic structure and environment’s impact on their work with clients who have disabilities.*

The person with a disability is the ultimate authority on his or her own needs. To support individual freedom and choice, a psychologist provides a hospitable environment for psychological intervention (Banks & Kaschak, 2003), and attempts to understand how the individual’s environment affects his or her disability.

Accordingly, in keeping with the accessibility considerations in Guideline 3, the psychologist working with a client who has a disability is encouraged to:

a) Maintain the length of sessions flexible to accommodate the client’s physical and psychological resources. For instance, when a client experiences fatigue due to travel or poorly controlled pain, a full-length therapy session may be too exhausting.

b) Tailor the number, nature, and frequency of sessions to the client’s stamina, attention span, ability to process content of sessions, and transportation resources.

c) Accommodate the communication needs of clients with language processing, attention and memory problems by providing visual aids and written summaries, or audio-taping sessions.

d) At the beginning of therapy, explain to the client and any other people who may accompany the client (e.g. interpreter, personal attendant, family
member(s), or significant other) that the APA *Code of Conduct* (Principle 4, Privacy and Confidentiality: part 01, maintaining confidentiality, and part 02, discussing the limits of confidentiality, *Ethical Principles of Psychologists and Code of Conduct*, 2002) establishes the client’s right to confidentiality.

*Guideline 19: Psychologists strive to recognize that interventions with persons with disabilities may focus on enhancing well being as well as reducing distress and ameliorating skill deficits.*

Because a disability often involves motor, cognitive, sensory, or mental health impairment(s), a psychologist may wrongly assume that a therapy client with a disability wishes to focus primarily on the disability or its effects (Dunn & Dougherty, 2005; Dykens, 2006; Olkin, 1999b; Reeve, 2000). Although some clients with disabilities may struggle with feelings of loss or need appropriate skills training, many others simply want better lives. For example, some clients might want psychological support to enhance their quality of life by resolving relationship problems, making career choices, or developing strategies to transition to their next development stage (Eklund & MacDonald, 1991).

People with disabilities have strengths like everyone else. A client whose strengths are recognized and enhanced has a more positive self-image and ability to deal with life issues (Dunn & Dougherty, 2005; Dykens, 2006; Olkin, 1999b). Personal strengths include education, personality traits, creativity and talent, social relationships, and access to necessary supports. Interventions that consider the personal strengths of a client with a disability increase the individual’s self worth, empowerment, and resiliency (Dunn & Dougherty, 2005; Dykens, 2006).

The choice of intervention depends on the client’s reasons for seeking psychological services. Interventions may focus on increasing self-determination, or being empowered to make one’s own decisions and choices about life (Duvdevany, Ben-Zur, &
Ambar, 2002; Nota, Ferrari, Soresi, & Wehmeyer, 2007; Shogren, Wehmeyer, Reese, & O’Hara, 2006). Working with a client to develop his or her self-advocacy skills promotes self-determination (Goodley & Lawthom, 2006; Olkin, 1999b; Reeve, 2000). The person who advocates for her own social, economic and political opportunities and personal relationship needs may have a greater sense of empowerment and well being.

Guideline 20: When working with systems that support, treat, or educate people with disabilities, psychologists strive to keep the clients’ perspectives paramount and advocate for client self-determination, integration, choice, and least restrictive alternatives.

Many community agencies and systems influence the lives and psychological well being of individuals with disabilities and their families (DeJong, 1979; DeJong, 1983; Heinemann, 2005; Hernandez, Balcazar, Keys, Hidalgo, & Rosen, 2006). The psychologist who works with organizations that serve individuals with disabilities promotes inclusive environments and supports clients with disabilities by consulting with individuals and groups, meeting with collaborative teams, and creating beneficial adaptations and accommodations.

A psychologist supports the aspirations of clients with disabilities by involving each client or her family in intervention and educational planning, individual choices and self-determination, independence, integration, and welfare (Bannerman, Sheldon, Sherman, & Harchik, 1990; Gill et al., 2003). For example, a psychologist working with an adolescent student who has an intellectual or learning disability might collaborate to involve the student and family in developing an Individual Education Plan (IEP) and making life choices (e.g., Combes, Hardy, & Buchan, 2004). The psychologist might train other service providers in active listening strategies or in ways to determine preferences of individuals with communication disabilities. Similarly, a psychologist might provide organizational consultation and skills training to a support group for adults with mobility
impairments who are eager to advocate for social change (e.g., Hernandez et al., 2006). In each example, a psychologist works with disabilities service systems to jointly maximize the client’s involvement in all appropriate decisions and ensure that the client receives appropriate services.

*Guideline 21: Psychologists strive to recognize and address health promotion issues for individuals with disabilities.*

Psychologists recognize that disability is not a disease or illness, and that individuals with disabilities may experience secondary health conditions that affect their well being and participation in community life (Kinne, Patrick, & Doyle, 2004; Ravesloot, Seekins, & White, 2005; WHO, 2001). Individuals with disabilities often lead healthy and independent lives, but may have a smaller margin of health and be at increased risk for several preventable and manageable secondary health conditions (e.g., Kinne et al., 2004; Pope & Tarlov, 1991).

Given that physical and mental health are intimately related, psychologists can help clients with disabilities understand how maintaining health and preventing secondary conditions can help them achieve life goals. When appropriate, psychologists learn about their clients’ health issues, help their clients understand the relationship between health and well being, and encourage clients to practice healthy lifestyles that prevent both primary and secondary health problems (Gill & Brown, 2002; Heller, Hsieh, & Rimmer, 2002; Heller & Marks, 2002).

Psychologists are encouraged to read the Surgeon’s General *Call to Action to Improve the Health and Wellness of Persons with Disabilities* (2005), which states that professionals have a role in advancing the good health of persons with disabilities. The *Call to Action* discusses the challenges, strategies, and research priorities required to help individuals with disabilities lead healthy and productive lives.
Training and Education

Guideline 22: Psychologists strive to increase their knowledge and skills about working with individuals with disabilities through training, education, and expert consultation.

A psychologist’s competence in the area of disability affects the validity, reliability, fairness, and appropriateness of assessments and interventions. Even highly trained and experienced professionals need continuing education in the areas of disability testing, accommodations, evolving technology, and federal and local laws governing disability issues (Holzbauer & Berven, 1999). Continuing education may include Division/State Association workshops, academic disability studies courses and certificate programs, re-specialization programs, post-doctoral fellowships, self-study, disability-related coursework, working with a mentor, and/or seeking supervision.

Professional journals and various professional organizations publish a wide range of research and practice literature relevant to working with people with disabilities. Disability-related articles appear in several APA journals, including the American Journal of Orthopsychiatry, Families, Systems, & Health, Health Psychology, Journal of Consulting & Clinical Psychology, Journal of Counseling Psychology, Neuropsychology, Professional Psychology: Research and Practice, and Psychology, Public Policy, and Law. The following APA divisions offer disability-relevant information and research: Division 22 (Rehabilitation Psychology); Division 27 (Society for Community Research and Action); Division 33 (Intellectual and Developmental Disabilities); and Division 43 (Family Psychology).

A psychologist should consult an expert about ethical dilemmas. Developing and regularly consulting with a network of colleagues may facilitate ethical decision making. The Ethical Principles of Psychologists and Code of Conduct (APA, 2002) and local and national boards are also good resources for ethical decision-making (Rae et al., 2001).
Psychologists are encouraged to become familiar with disability resources in their communities. Examples of resources might include local Centers for Independent Living, State assistive technology projects and support groups. Such organizations can provide valuable information about disability for psychologists, and be helpful resources to their clients with disabilities.

**Concluding Statements**

The *Guidelines for Assessment of and Intervention with Individuals Who Have Disabilities* is an invitation to dialogue, not a set of directives. It is a living document that will evolve as research, practice and training advance. The *Guidelines* have several key messages. First, psychologists are uniquely positioned to help individuals with disabilities become self-determined citizens of our diverse society. Second, disability is a biopsychosocial construct that reflects a dynamic interaction of individuals with their various environments. Psychologists may optimize this interaction by collaborating with clients who have disabilities and the systems that affect them. Third, psychologists may ensure validity, fairness and appropriateness of assessments and interventions by critically evaluating their own possible biases and ideas about disability. Fourth, rather than focusing on disability alone, psychologists are encouraged to help the individual discover and balance personal strengths and limitations. Fifth, psychologists promote equal access and equal opportunity for persons with disabilities by using all necessary accommodations in their procedures and practices. Lastly, psychologists who work with clients who have disabilities maintain their skills and knowledge disabilities by actively seeking disability-related training, education and consultation.
References


Balancing the right to habilitation with the right to personal liberties: The rights of people with developmental disabilities to eat too many doughnuts and take a nap. *Journal of Applied Behavior Analysis, 23*(1), 79-89.


Sometimes you just want to feel like a human being: Case studies of empowering psychotherapy with people with disabilities. Baltimore: Paul H Brookes.


Introduction to the special section on the international classification of functioning, disability and health: Implications for rehabilitation psychology. *Rehabilitation Psychology, 50*(2), 103-104.

The international Classification of Functioning, Disability and Health: Contemporary literature overview. *Rehabilitation Psychology 50*(2), 113-121.


The movement for independent living: Origins, ideology, and implications for disability research. In A. Brechin & P. Liddiard (Eds.), *Handicap in a social world*, Milton Keynes, Hodde, and Stough in association with the University Press (pp. 239-248).


National Task Force on Technology and Disability. (2004). Within our reach: Findings and recommendations of the National Task Force on Technology and Disability.


Olkin, R. (1999a). The personal, professional and political when clients have disabilities. Women & Therapy, 22(2), 87-103.


Smart, J. (2001). Disability, society, and the individual. Austin, TX: Pro-Ed.


