Disabling Psychology: A Crip Analysis of Deaf and Blind Psychotherapists in Practice

Kathryn Irene Wagner

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DISABLING PSYCHOLOGY: A CRIP ANALYSIS OF DEAF AND BLIND
PSYCHOTHERAPISTS IN PRACTICE

A Dissertation
Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements
for the degree of Doctor of Philosophy

By
Kathryn I. Wagner

August 2016
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Kathryn Irene Wagner

2016
DISABLING PSYCHOLOGY: A CRIP ANALYSIS OF DEAF AND BLIND

PSYCHOTHERAPISTS IN PRACTICE

By

Kathryn Irene Wagner

Approved May 23, 2016

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ABSTRACT

DISABLING PSYCHOLOGY: A CRIP ANALYSIS OF DEAF AND BLIND PSYCHOTHERAPISTS IN PRACTICE

By

Kathryn Irene Wagner

August 2016

Dissertation supervised by Dr. Lori Koelsch

This dissertation explores the phenomenological experience of d/Deaf or blind psychotherapists who work with nondisabled clients, seeking to understand the perceived impact of disability on the therapeutic relationship. There is an abundance of research on nondisabled therapists treating disabled clients but only a handful of studies qualitatively considering the disabled therapist’s understanding of practicing in a largely ableist world. Six deaf and eight blind therapists were interviewed for this dissertation. Results were qualitatively analyzed using interpretive phenomenological analysis (IPA). Results were also interpreted through a critical disability studies framework with an eye toward challenging the ableism embedded within traditional research practices (cripping them, in the language of disability studies). An autoethnographic analysis was incorporated with respect to the researcher’s own experience practicing as a deaf therapist, and a member check was utilized with select participants to get feedback on the results.
The range of explicit and implicit themes that emerge from the researcher’s analyses include the systemic challenges that deaf and blind therapists face in the work setting; the impact of self-disclosure on patient reactions to disability; the nuanced ways the therapist’s disability influenced the alliance, transference, and countertransference; and the therapists’ own complicated relationships to their disabilities. Participant stories about working with well-meaning but ill-informed supervisors also highlighted the lack of instruction in disability studies and larger systems of oppression in graduate training programs and continuing education courses. Interpreted through a critical disability studies framework, these results crip normative beliefs about disability (as something one must “overcome”) and problematize traditional qualitative research practices.

Conversations occurring at the intersections of psychology and gender and psychology and race have shed much insight into marginalizations occurring within the therapy space. Though disability issues are coming to the forefront, psychology has yet to take on board the critical insights of disability studies. If psychology wants to contribute to disability studies, the field as a whole needs to move away from the medical and even sociopolitical models of disability in order to take seriously the lived experiences of disabled people on their own diverse terms. In arguing that ableism must be removed as the norm, this project offers some suggestive glimmers of what it might mean to challenge normative beliefs about disability within psychology and qualitative research practices.
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>iv</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>vi</td>
</tr>
<tr>
<td>Chapter 1: Introduction and Literature Review</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Introduction</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Disability Studies Terminology</td>
<td>2</td>
</tr>
<tr>
<td>1.3 Literature Review</td>
<td>4</td>
</tr>
<tr>
<td>1.4 Utilizing a Disability Studies Perspective</td>
<td>17</td>
</tr>
<tr>
<td>1.5 Gaps in the Literature</td>
<td>18</td>
</tr>
<tr>
<td>Chapter 2: Rationale for Methods and Methodology</td>
<td>20</td>
</tr>
<tr>
<td>2.1 Introduction to Research Methodology: A Disability Studies Framework</td>
<td>20</td>
</tr>
<tr>
<td>2.2 Interpretive Phenomenological Analysis</td>
<td>23</td>
</tr>
<tr>
<td>2.3 Autoethnography</td>
<td>24</td>
</tr>
<tr>
<td>2.4 Member Check</td>
<td>26</td>
</tr>
<tr>
<td>2.5 Rationale for Mixed Methods Approach</td>
<td>27</td>
</tr>
<tr>
<td>Chapter 3: Data Collection and Steps Toward Analysis</td>
<td>30</td>
</tr>
<tr>
<td>3.1 Introduction to Method</td>
<td>30</td>
</tr>
<tr>
<td>3.2 Participant Selection Criteria, Recruitment, and Demographics</td>
<td>30</td>
</tr>
<tr>
<td>3.3 Interview Data Collection and Method of Analysis</td>
<td>35</td>
</tr>
<tr>
<td>Method 1: IPA: Step-by-Step</td>
<td>38</td>
</tr>
<tr>
<td>Method 2: Autoethnographic Analysis</td>
<td>44</td>
</tr>
<tr>
<td>3.4 Member Check Procedure</td>
<td>45</td>
</tr>
<tr>
<td>3.5 Rationale for Participant Data Collection</td>
<td>45</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>8.2 The Phenomenological Experience of Disability</td>
<td>167</td>
</tr>
<tr>
<td>8.3 Looking Ahead: Psychology and Disability Studies <em>can</em> Join Hands</td>
<td>170</td>
</tr>
<tr>
<td>8.4 Suggestions for Future Research</td>
<td>172</td>
</tr>
<tr>
<td>8.5 Limitations to Dissertation</td>
<td>174</td>
</tr>
<tr>
<td>8.6 Closing Reflection</td>
<td>175</td>
</tr>
<tr>
<td>References</td>
<td>177</td>
</tr>
<tr>
<td>Appendix A: Recruitment Letter</td>
<td>188</td>
</tr>
<tr>
<td>Appendix B: Screening Questions</td>
<td>189</td>
</tr>
<tr>
<td>Appendix C: Consent Form</td>
<td>190</td>
</tr>
<tr>
<td>Appendix D: General Interview Questions</td>
<td>192</td>
</tr>
<tr>
<td>Appendix E: Member Check Letters</td>
<td>193</td>
</tr>
<tr>
<td>Appendix F: Clustered Themes: Final Round of Coding</td>
<td>195</td>
</tr>
<tr>
<td>Appendix G: Master Table of Themes</td>
<td>197</td>
</tr>
<tr>
<td>Appendix H: IPA Individual Analyses</td>
<td>225</td>
</tr>
<tr>
<td>Octavia</td>
<td>225</td>
</tr>
<tr>
<td>Melissa</td>
<td>234</td>
</tr>
<tr>
<td>Nadine</td>
<td>240</td>
</tr>
<tr>
<td>Grace</td>
<td>250</td>
</tr>
<tr>
<td>Anna</td>
<td>255</td>
</tr>
<tr>
<td>Sophia</td>
<td>258</td>
</tr>
<tr>
<td>Alex</td>
<td>264</td>
</tr>
<tr>
<td>Jaime</td>
<td>273</td>
</tr>
<tr>
<td>Bella</td>
<td>283</td>
</tr>
<tr>
<td>Brenda</td>
<td>286</td>
</tr>
</tbody>
</table>
Jake 289
Donna 292
Ellen 296
Chapter 1

Introduction and Literature Review

1.1 Introduction

“You remind me of my deaf mother,” Jane said to me, in a particularly intense session three months into treatment. She was recalling moments in her childhood when she felt angry with her mother for “talking funny” and embarrassing her in front of her classmates. A novice therapist at the time, I tried to explore this sensitive memory with her, to empathize with what she was feeling, but she blushed, clenched her jaw, and turned her body away from me. For the rest of the session she was somewhere else far away, perhaps hearing her mother’s “funny voice” that was similar to my own. She cancelled the following session with a message that her friend had the name of another therapist who was “skilled and older” – and presumably who was not deaf. I realized later that Jane probably experienced my empathy as insincere. Possibly she thought I was relating to her mother, not her.

A few years later a Vietnam Veteran came to see me for treatment. Having learned that I understand by lipreading, Mike frequently began sessions with a long-winded commentary about how he “must not cover [his] mouth” otherwise I would not hear him. Yet his hand never strayed far from his lips when he was speaking, especially at what seemed like important moments in his war story. Other hearing clients have reported that my gaze seems especially intense; one client reported that I “stared at [her] too hard.” These are just a few examples among many that directed me to my research path as I wondered how sensory disabilities, specifically deafness and blindness on the part of the therapist, were experienced and discussed by nondisabled patients in the consulting room.

The goals of my dissertation are threefold: to explore the lived experience of
psychotherapists who present with a sensory disability (i.e., deafness or blindness); to understand how this difference impacts the therapeutic relationship with nondisabled clients; and to learn how such experiences can contribute to ongoing conversations at the intersection of psychology and disability studies. The disabled therapist’s experience is necessary to understand because, as Allison G. Freeman (1994) points out, “transferential and counter-transferential issues related to the therapist’s disability often arise in therapy” (p. 80). Moreover, given the dearth of research in disability issues within the psychology field, understanding the lived experience of psychotherapists who are deaf or blind can provide invaluable insights into ableist privilege as it plays out within the profession. Studying disability is a “prism through which one can gain a broader understanding of society and human experience” (Linton, 1998, p. 118), including how individuals in conversation (such as in therapy) respond to one another. In the service of these goals, I utilize two qualitative methods of analysis – interpretive phenomenological analysis (IPA) and autoethnography – as situated within a disability studies framework.

1.2 Disability Studies Terminology

Before proceeding further, it is imperative to briefly discuss the different terms that will appear throughout this dissertation, especially as they relate to the different models of disability and the language people use when talking about disability and impairment.

**Impairment vs. disability.** The language of impairment most often refers to a person’s medical or congenital condition that may cause them to experience a difference in physiological function; i.e., blindness means that one cannot perceive the world visually. As defined by the Disabled People’s International Organization, impairment is the “functional limitation within the individual caused by physical, mental or sensory impairment” (Oliver,
Comparatively, that same organization defines disability as “the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers” (Oliver, 1996, p. 31). In recent years new, more complex, understandings of disability have appeared in the literature. Queer studies scholar Robert McRuer (2008) creatively defines disability as an “open mesh of possibilities, gaps, overlaps, dissonances and resonances, lapses and excesses of meaning that occurs when one’s sensory functioning doesn’t signify the normative experience” (p. 245).

**Person first vs. identity first.** Person-first language “puts the person before the disability or the condition, and emphasizes the value and worth of the individual by recognizing them as a person instead of a condition” (Brown, 2011, para. 7). In other words, to speak in person-first language is to say, “people with autism” or “people with hearing impairments.” Yet, as autistic scholar Lydia Brown points out, when we say “people with disabilities,” there is an “attitudinal nuance” in that it suggests that people can be separated from their disability, that disability is negative and something one would not want to see. But can people be separated from disability? It’s not quite that simple, as Cara Liebowitz (2015) points out when she quips, “it’s not as if ‘person’ is a standard action figure, while ‘disability’ comes in the accessory pack designed to make you spend more money” (para. 3).

Identity-first language suggests that, just as we cannot separate a person from their gender or color of skin, it is impossible to separate someone from disability. We would not say a “person with blackness” or a “person with Jewishness.” Identity-first language is founded upon the social model of disability, which states that though our impairments (our diagnostic, medical conditions) may limit us in some ways, it is the inaccessibility of society that actually disables us and renders us unable to function. If one of my interview participants cannot upload her notes because the program she is using is not compatible
with a screen reader, it is the inaccessibility of the program that disables her rather than her blindness. Throughout this dissertation, I frequently switch between person-first and identity-first language, not to suggest they are interchangeable but to represent the preferences of my participants with respect to their relationship to disability.

**Crip/Crip Theory.** “Crip,” an abbreviation of the insult “cripple,” has been taken up as a self-definition by disabled people who wish to reclaim the stigmatized term, in a manner similar to LGBT reclamation of “queer.” Victoria Ann Lewis writes that crip “signals in-group status and solidarity and is intended to deflate mainstream labels,” adding that it is “most often embraced by educated disabled people who have some understanding of the historical and political significances of their experiences as disabled and who want to reclaim a stigmatized term” (2015, p. 49). Originating in activist and artistic contexts, the term has been important to disability studies scholarship in literary and cultural studies since the mid-2000s. Carrie Sandahl (2003) writes that the term, along with “queer,” signals “a radical stance toward concepts of normalcy” (p. 26). Pushing further than the sociopolitical understanding of disability, a crip model of disability in this sense would not simply seek inclusion into a more accessible world but would challenge the norms and power structures that define accessibility and inaccessibility in the first place, a framework developed by Robert McRuer in his 2006 book *Crip Theory*. He argues that it is not just individual disabled people who should claim a crip standpoint but that social, material, and economic conditions themselves must becripped, or upended, in order to challenge the social order of compulsory able-bodiedness in which we are all implicated.

### 1.3 Literature Review

The following literature review provides an overview of historical and recent
publications at the intersection of disability and psychology. In this section I explore the different attitudes to and models of disability, as well as disability with respect to the larger psychology field. It is vital to explore the following topics, as these models influence – consciously and unconsciously – my participants’ and their patients’ views about disability. I also discuss the literature on supervision of graduate students with disabilities and disability studies within psychoanalysis. Little has been published on the conjunctures of disability and psychotherapy that my work explores, especially with regard to visible disabilities (Glover & Janikowski, 2001; Leisener & Mills, 1999). By portraying the ways in which disability has been discussed, I draw attention to the areas of absence within this field.

**Models of disability.** Before the emergence of critical disability studies, the subject of disability was most often studied in the health, medical, and rehab fields, and was largely framed “as a medical problem needing a medical solution” (Garland-Thompson, 2013, p. 915). This perspective, which stemmed from the biomedical model of disability, suggested that something was wrong with the person, that the person was responsible for the solution. Taken to its extreme, the normative aspect of this model views a perfect world as one without disabilities because there is nothing beneficial about disability (Smart & Smart, 2006). When the problem was defined as medical, conversations about disability happened behind closed doors and often did not involve the individual in question; rather disability was viewed as something that only doctors could discuss (Olkin & Pledger, 2003). This rather outdated model, which has been challenged by those with disabilities, has contributed to the silencing of disability in professional fields, including psychology, as it rarely considered the disabled individual’s lived and sociocultural experience. This view was also problematic in that it furthered the notion that people with disabilities could somehow be “fixed” with appropriate treatments (Smart & Smart, 2006).
Emerging from critiques of the medical model, the functional or environmental model defines disability in relation to the abilities and achievements of the individual. It does not view the problem of disability as located entirely within the individual but it also does not place the blame on society; instead the goal is to assist the individual, to rehabilitate them, to help them succeed. This model posits that society can cause disabilities, embellish disabilities, and, in the words of some disability scholars, “make” disabilities (Higgins, 1992; Smart & Smart, 2006). In this way, the functional model might be seen as a revision of the medical model. A problem with the functional and environmental model is that many disabled individuals do not want the help of society to rehabilitate them, especially from a society that is mostly nondisabled. Harilyn Rousso (2013) makes a case for this in her creative memoir, Don’t Call Me Inspirational: A Disabled Feminist Talks Back. She argues that the help of others, even if well-intended, can make a disabled person feel helpless, and that being called “inspirational” is patronizing, as it is the disability rather than the person on display.

As people began claiming disability as an identity (thus the emergence of identity-first language), perspectives on disability moved away from the medical and functional models to the social model, sometimes known as the sociopolitical model, and the springboard for the emergence of disability studies as a scholarly field. Much like how gender studies builds on the understanding of gender as socially constructed, disability studies builds on the notion of disability as being socially constructed where the “limitations and disadvantages experienced by people with disabilities” are created by the world in which they live (Smart & Smart, 2006, p. 34). A wheelchair user is disabled not because they are unable to walk but because most buildings are designed in a manner that excludes access. This model purports that disability, and research about disability, can only be defined by the
disabled persons under study. In other words, as James Charlton (2000) describes in his book, *Nothing About Us Without Us: Disability Oppression and Empowerment*, about social movements worldwide working toward the liberation of people with disabilities from systemic oppression, people with disabilities know what is best for them and can make their own choices. Yet the sociopolitical model is not without difficulties. For example, it does not answer the question why, and in what ways, disability is “othered” by nondisabled persons. It also does not consider the lived experience of the disabled person as it plays out in the here-and-now of their worlds (such as the therapy world), which is what I attempt to explore in this dissertation.

A fourth model, and perhaps the most eclectic, draws from Robert McRuer’s work on crip theory, which embraces the idea that the disabled should not only claim identity but also grapple with its limitations and contradictions. Crip theory argues that able-bodiedness (like heterosexuality) masquerades as a non-identity and “produces disability” by contrasting disabled bodies with the unmarked, supposedly natural state of able-bodiedness. However, the “production” of disability should not be interpreted as negative or wrong, as the disabled body is human and the human body is always fragmented, disordered, and messy (McRuer, 2006). From this perspective, disability, like psychotherapy, is about noticing and connecting with the parts within us that are fluid and outside our control. Disability, like psychotherapy, embraces the unfinished, the partial, the contradictory, the unruly, and the incoherent (McRuer, 2006). Crip theory, however, is not without problems. As a philosophical approach, rather than a model that is intended to be actionable, this perspective needs revision and development in order to be a useful model for psychology – and developing it into a usable model is part of the work that my project does. Crip theory does not address the here-and-now of disability; it does not address the need for a provisional separation.
between the disabled and nondisabled such that the intricate phenomena of the disabled person’s experience can be isolated and understood, then generalized and questioned. The distilling of such experiences is necessary if we are to complicate the meaning of disability in psychotherapy.

These various models of disability, with the exception of crip theory, are informed by and continue to inform mainstream attitudes about disability, which are propagated by a variety of counseling practitioners, and have contributed to how disability is discussed – and misrepresented – in society as well as the psychotherapy space. Attitudes toward the disabled can range from negative (including that of embarrassment) to positive (including idealization) (Murdick et al., 2004), and such attitudes draw from cultural definitions of “normal” as well as personal feelings of anxiety about disability or becoming disabled. In the media and even in popular psychology journals, conversations about disability range from the discriminatory to the positive (Olkin & Pledger, 2003), often with little conversation about the complexities of one’s experience.

By the time an adult client presents for therapy, it is likely that they have formed an opinion about disability that then informs how they relate to their therapist – often an overwhelmingly negative or positive view. In an article addressing theoretical and clinical issues for therapists with disabilities, Asch and Rousso (1985) provide some rationales for clients’ negative or discriminatory views: disability is a punishment for sins; disability is contagious and will spread to those who have contact (especially tactile contact) with the disabled; and disability implies helplessness, dependency, and inferiority. On the positive side, clients may believe that the disabled are courageous, moral, empathic, and possess unique gifts that compensate for their limitations (Asch & Rousso, 1985; Calonico, 1995;
Freeman, 1994). Such positive attitudes are reasons why clients might seek out a disabled therapist, a topic further explored in the results section of this dissertation.

**Disability and psychology: Convergences and divergences.** The first known appearance of disability in the psychology field began with Sigmund Freud (1856-1939), who experienced difficulty communicating due to oral cancer (Calonico, 1995; Halpert, 1982). That Freud did not speak about his condition with his patients or colleagues is not surprising given his psychoanalytic view that the therapist’s subjectivity existed only outside of the therapy relationship. In fact, for many decades disability was not part of conversations in psychology and psychoanalysis but was considered a domain of rehabilitation and occupational therapy. We can wonder if the lack of disability research in psychology reflected the pervasive discomfort, guilt, and anxiety that nondisabled people felt in the presence of a person with a disability (Foley-Nicpon & Lee, 2012; Shakespeare, 2006).

The literature on disability with respect to psychology falls into four broad areas, the first three being the most prevalent: clinical supervision of disabled graduate students by nondisabled academics; training in disability studies for clinical psychology students; and disabled clients working with nondisabled therapists. The fourth area, and primary focus of my dissertation, the issues faced by disabled therapists, has only recently generated attention.

**Supervision of disabled graduate students.** The few studies on graduate students with disabilities focus on supervision practices and self-disclosure. Rhoda Olkin (2010), a disabled therapist, questions whether it is ethical for a supervisor to require a trainee with a visible disability to disclose their disability to prospective clients before the first meeting. Her research suggests that such request originates from the supervisor’s views of disability, for example, as a medical condition or a social construction. If a supervisor views disability as a medical problem they may expect the supervisee to disclose, whereas someone who sees
disability as a social construction might feel more comfortable allowing the supervisee to decide what is best for him or her with regard to self-disclosure. When a supervisor requests that trainee disclose a disability before meeting the patient, the opportunity to develop a relational and clinical encounter upon meeting is foreclosed (Taube & Olkin, 2011). On another note, Linda Calonico (1995) found that therapists perceived their clients to be significantly more accepting of their disabilities than colleagues or supervisors; reasons for this were not fully explored as her research utilized a quantitative approach.

**Training in disability issues.** Research indicates that in graduate clinical and counseling psychology programs, disability received the least focus as compared to other diversity issues, such as ethnicity, gender, sexual orientation, and religion (Kemp & Mallinckrodt, 1996; Olkin, 2002). Additionally, when disability is discussed it is often not from a disability studies perspective but rather from a medical perspective. Kemp and Mallinckrodt (1996) found that most clinical programs do not include disability issues in their curriculum, and they concluded, through quantitative studies, that even a “small amount of training on issues of disability [is] associated with significantly less bias in case conceptualization and treatment planning” (p. 383). While this specific topic may not seem directly relevant to my driving question, it has inevitably shaped the experiences of many of my participants, from their first day of graduate school to licensure and retirement.

**Clients with disabilities.** Research at the intersections of psychology and disability includes therapists acknowledging, confronting, and dealing with their own fears and biases toward disabled clients in order to provide optimal therapy (Vogel & Bowers, 2004). This juncture includes research on body objectification (e.g., Keary, 2009), therapists learning how to sensitively inquire about the client’s disability (e.g., Artman & Daniels, 2012), the effect of a client’s disability on the therapist (e.g., Segal, 1996), and disabled clients working with
disabled therapists (e.g., Cohen, 2000; Freeman, 1994).

**Therapists with disabilities.** As determined by psychology database searches, research in the area of therapists with disabilities is still in its infancy (Mallinckrodt & Helms, 1986; Miller, 1991). The existing literature includes quantitative studies on self-disclosure, the therapeutic alliance; the assumptions that the nondisabled make about therapists with disabilities; and disabled therapists’ personal journeys.

In many academic and professional fields, “disclosure of one’s relationship to disability is often considered to be private information” (O’Toole, 2013, para. 7). In psychotherapy, however, it is much harder to avoid disclosing a visible disability such as deafness or blindness, as it makes itself felt in the therapy dynamic between therapist and patient. Additionally, the therapist’s relationship to his or her disability – that is, comfort level – impacts disclosure styles. Corbett O’Toole asks (2013):

> [If a therapist] does not appear to have an impairment but chooses to say, ‘I am disabled’ does that mean [she] has to disclose her impairment? If yes, [does she] have to say something about the severity of the impairment? (para 46)

O’Toole’s comment addresses the power dynamic inherent in the therapy relationship; it inherently speaks to the question, “Who gets to decide how much the therapist discloses? The patient, who is paying, or the therapist?” My participants’ stories about their own process of self-disclosure address this question.

The research on therapist self-disclosure incorporates a variety of views, spanning from strong discouragement of disclosure (most common in psychoanalysis) to encouragement of full disclosure (most common in humanistic or client-centered psychotherapy) (Mahalik, Van Ormer & Simi, 2000; Olkin, 2002). The most frequent example of therapist disclosure is for the purpose of modeling appropriate behavior or
coping strategies. Linda Calonico (1995) found that therapists, regardless of orientation, disclosed just enough to put the client at ease and to make the therapist’s disability an acceptable topic for discussion, but not so much that the client was made uncomfortable or that the client felt his or her issues were unimportant or insignificant by comparison. Studies have also indicated that when a therapist presents with a visible disability, early self-disclosure is effective in creating a strong rapport and reducing the client’s anxiety (Mallinckrodt & Helms, 1986; Miller, 1991).

The research on therapeutic alliance between disabled therapists and disabled or nondisabled clients focuses on client preferences and therapeutic outcomes. A study conducted in 1973 found that the majority of undergraduates surveyed preferred a therapist with a disability because they felt the disabled therapist could better empathize with their problems (Brabham & Thoreson, 1973). Although this research is outdated, it harks back to my earlier remarks about positive attitudes toward disability. People with disabilities are often viewed as courageous and empathic; they are imagined to possess unique gifts that compensate for their limitations. Nearly two decades after Brabham and Thoreson’s research, MJ Miller (1991) proposed the idea of the “additive view,” which hypothesized certain advantages for a disabled therapist. The additive view contends that the disabled therapist is evaluated more positively for succeeding in spite of the disability; therefore, they are expected to have a better understanding of other people’s problems. According to Miller’s research, therapists with disabilities are favored over nondisabled therapists by nondisabled clients (Miller, 1991).

Past studies have highlighted the positive and negative perceptions that many nondisabled clients have about therapists with disabilities. One the one hand, therapists with disabilities were viewed as having overcome severe hardship; were perceived as being more
empathic and genuine by nondisabled clients, and were often seen to represent positive role models (Belgrave & Mills, 1981; Brearly, 1980; Miller, 1991; Mitchell & Allen, 1975; Mitchell & Frederickson, 1975). From a negative standpoint, past studies show that client assumptions about disability sometimes led to higher drop out rates (Bowman, 1979; Mallinckrodt and Helms, 1986; Stovall and Sedlacek, 1981).

Mallinckrodt and Helms (1986) set out to explore some of the positive and negative perceptions clients had about therapists with disabilities, specifically with respect to the role of self-disclosure. They invited over 100 undergraduate students to look at clips of two therapy sessions: between a therapist with a visible disability and a nondisabled client and a therapist with an invisible disability and a nondisabled client. Results from the study suggested that students most often preferred the therapist with the visible disability because they believed that the therapist was more empathic to life struggles. While Mallinckrodt and Helm’s (1986) study highlights assumptions made by nondisabled clients it does not discuss the timing of self-disclosure or the actual lived experience of what it would be like for these clients to be in therapy with the disabled therapist, including how social perceptions of disability impact the therapeutic alliance.

Michael Axelman and Dokie Riahi Kashani (2009), graduate students at a mid-western university, conducted two focus groups to explore the issues that arise when an able-bodied client works with a therapist who is disabled. These authors were interested in exploring underlying beliefs about disability, the role of disclosure on client reactions, and whether the nature of the disability impacted the client’s perceptions. Three panelists with different visible disabilities (spinal cord injury, congenital quadriplegia, and visual limitation) were invited to converse with an audience of focus group participants. With the help of a moderator, the participants discussed what they imagined might take place if they were to
see any one of these three panelists for therapy. Participants discussed their thoughts and reactions, and as well as resistance to sharing their thoughts with the panelists.

Results from focus group conversations indicated the following: participants wanted to know about the nature of the disability, participants felt the urge to question the professional capacity of the disabled therapist, and participants desired to be forewarned about the disability before the first meeting (Axelman & Kashani, 2009). Participants also discussed their wish for the therapist to normalize participant anxiety as well to as serve as role models to contradict previous learning about disability; that is, “to provide a corrective experience [...] to assuage [...] anxiety, and to enhance the client’s own self disclosure throughout therapy” (Axelman & Kashani, 2009, p. 36). The authors also discussed the complexities of participant responses, as demonstrated in the following excerpt:

It is noteworthy that three attendees expressed ambivalent attitudes towards a counselor with a visible disability. For instance, the same individual that sated, “Are they mentally fit 100%?” also noted that, “I admire the courage with which they live life.” Such polar attitudes may well add consistently to the complexity that exists within the therapeutic relationship between an able-body client and a counselor with a visual disability. (p. 34)

This study is important in that it highlights some of the assumptions that able-bodied people might have when going to see a therapist with a disability. But the research also has a lot of flaws. For one, there was no discussion about what it was like for the panelists with disabilities, placed in a vulnerable position, to hear and process the responses from participants. I imagine it was not always easy for them to take in negative perceptions, especially with respect to their mental capacity to perform the job. Additionally, the study did not draw on lived experiences of therapists and clients working together; that is, being a
client of a therapist with a disability is very different than trying to imagine that experience. Finally, the study described itself as focusing on “issues faced by therapists with disabilities” but the research really highlighted the biases faced by the participants, not the panelists.

Research also shows that a client’s initial reactions to the therapist’s disability may influence diagnostic perceptions, course of treatment, and issues of transference and countertransference (Calonico, 1995; Freeman, 1994). Alison Freeman (1994) purports that some clients may react with feelings of anxiety and fear that the disabled therapist may not be able to meet their needs or handle their anger. Conversely, she states:

Some clients may feel hopeful or inspired by a disabled therapist thinking that she has overcome barriers and that the client herself can do the same. Other clients may look at the differences between themselves and their ‘damaged’ therapist who reminds them of their own ‘damaged’ self and feelings of vulnerability. (p. 80-81)

Qualitative and autoethnographic research by Brian Watermeyer and Leslie Swartz (2008) suggests that when one speaks about his or her disability, the resulting anxiety elicited in the observer triggers preconscious feelings of helplessness that are then managed through unsolicited actions or helping responses (harking back to the functional model of disability). When such helping actions are discouraged, as in traditional psychoanalysis, “the strong feelings at play may instead be managed via withdrawal, subtle blaming, dissociation, or a range of alternative modes of distancing” (Watermeyer & Swartz, 2008, p. 605). Some therapists may try to reassure the client, to protect the client from feelings of discomfort, or to take responsibility for the client’s feelings, in an interaction that Watermeyer and Swartz (2008) called a “distortion of psychic boundaries [in which] disabled people feel entitled to show only a partial version of subjective reality, through anticipating the emotional needs of the other” (p. 603). If disability triggers feelings of helplessness in the non-disabled, one can
imagine why that person might want to help the disabled in some way.

The literature on disabled therapists also includes personal journeys, such as the aforementioned work by Harilyn Rousso as well as Megan Turnbull’s (2005) article, *Embracing my Achilles’ Heel*. Both of these authors meditate on personal struggles in psychotherapy training, the difficulties and joys of connecting with nondisabled clients, and issues with self-disclosure and shame related to their disability. Rousso (2013) imagines questions clients might be thinking privately to themselves as they present for therapy. “Is she sick? What’s wrong with her? Does it hurt her? What happened to you? Were you born that way? Too bad there’s no cure” (p. 23). In sharing her experience of being othered by the nondisabled population, Rousso forces the reader to confront their own internal biases and prejudices about disability. Turnbull’s essay, which chronicled her journey as a blind therapist seeking Gestalt training, inspired me to approach this dissertation as a creative journey that pushes against the boundaries of scholarship and memoir, the political and the personal.

The literature on disability within the psychoanalytic field is sparse largely because, in Freud’s time, and for many decades after, it was thought that the disabled were “inherently non-analyzable and therefore could not be effective [clients or] therapists” (Blumenthal, 1982, para. 11). In the past few decades, however, a handful of analysts with disabilities have begun speculating about the unconscious dynamics occurring between themselves and their patients. David Tribich, a deaf psychoanalyst and Freudian scholar, told the following story at the Association of Mental Health Practitioners with Disabilities convention, as relayed by the writer Ralph Blumenthal in a 1982 *New York Times* article:

[Dr. Tribich’s patient expressed] an ‘extreme feeling of resentment at being confronted with a damaged analyst.’ The woman kept accusing him of not listening to her or not hearing her, he said. He was sure he was hearing her properly, but her
complaints even convinced his supervisor, Dr. Tribich said. But eventually, he said, he was able to show that the woman had felt since infancy that she was being ignored by her family and others, and that this was a key factor in her neurosis. (para. 16-17)

Despite this poignant conversation (at a convention which unfortunately no longer exists), Foley-Nicpon and Lee (2012) note that most research on disability and psychology exists outside of the realm of psychoanalysis and psychodynamic therapy. Perhaps this should not come as a surprise. If dynamic traditions focus on uncovering defenses and exploring the unconscious life of the client, the nondisabled therapist working within this orientation must be willing to face their own biases about disability and possible fears of becoming disabled themselves. Contrastingly, the therapist with a disability must be willing to face discrimination from nondisabled clients as well as possible feelings of envy toward the able-bodied client.

1.4 Utilizing a Disability Studies Perspective

Given that this dissertation focuses on the experiences of participants with disabilities – as well as the researcher’s own experience of disability – disability studies offers the most illuminating framework by which to understand the results of this project, especially when one considers the lack of intersections between psychology and disability studies. The simple act of talking about disability is different from understanding disability through a disability studies perspective.

As a critical field, disability studies is most often linked with race, queer, and gender studies, interdisciplinary areas that are often linked independently to psychology. But there is little discussion happening at the intersection of psychology and critical disability studies;
most conversations about disability issues occur in rehabilitation journals and lack critical perspective with respect to the sociopolitical barriers that many disabled people face.

According to Simi Linton (1998) a disability studies perspective is imperative in that it adds a “critical dimension to thinking about issues [within psychology] such as autonomy, competence, wholeness, independence/dependence, health, physical appearance, aesthetics, community, and notions of progress and perfection” (p. 118). A critical perspective asks one to consider how ability ideologies are constructed and how the experiences of privilege and oppression impact the lives of those with disabilities, especially those who may be oppressed in multiple ways (e.g., a person who is both queer and disabled or black and disabled). It also highlights the ways that able-bodied people’s lives are variously shaped by discourses of disability.

Also within disability studies is the notion of complex embodiment, coined by disability studies scholar Tobin Siebers (2010), which argues that the body and its interactions with the environment are intertwined. In other words, it is both the physical impairment as well as the social construction of disability that makes up the individual’s lived experience of moving through the world. Rather than being something that can be categorized and separated, the lived experience of disability, not unlike other marginalizations, is created and deconstructed by the society in which my participants live. This notion seems especially important when thinking about how disability plays out in the therapeutic interaction between therapist and client.

1.5 Gaps in the Literature

This literature review has provided an overview of research in the field of disability and psychology that is most relevant to my dissertation, including models of disability,
attitudes toward disability, disability research within psychology and psychoanalysis, and rationale for a disability studies framework.

Presently, gaps exist in the literature on disability studies and psychology that the results of this dissertation help to rectify. The first gap is lack of research on disability communities within psychology and how members of such groups identify their relationship to disability. Other fields, such as gender studies, have seen a proliferation of their members identifying as disabled and grappling with what it means to self-disclose at conferences and academic venues (O’Toole, 2013). Disability communities within the psychology field, however, are more private. For example, the APA website for the Committee on Disability Issues in Psychology lists a nondescript mission statement (e.g., to promote the psychological well being of persons with disabilities) that is factual rather than inviting and personal (APA 2016). From my own experience, I can report that disability is not well represented at mainstream psychology conferences or conventions.

Another gap is lack of qualitative research on the lived experiences of therapists with sensory disabilities, specifically the deaf and blind, and its impact on work with non-disabled clients. Most of the research cited in this introductory chapter utilized a quantitative methods approach, with a few utilizing a qualitative methods approach (e.g., interviews). By exploring the lived experience of therapists who are deaf or blind from the perspective of having the same disability as some of my participants, I hope to link together psychology with disability studies by utilizing a disability studies methodology as a framework with which to situate my methodological analysis, as discussed in the next chapter. By carefully analyzing my participants’ experiences of disability within the psychotherapy space, I aim to challenge normative narratives about disability and to contribute a new perspective on disability within the psychology field.
Chapter 2

Rationale for Methods and Methodology

“Methodology is not prescription, but movement, improvisation, revision” – Margaret Price, 2012

2.1 Introduction to Research Methodology: A Disability Studies Framework

According to Michael Oliver (1992) and John Rowan (1981), previous research on disabled populations often utilized a positivist or post-positivist paradigm: frameworks that rely on studying the “real” world through objective scientific methods and the researcher’s knowledge. A positivist model purports that it is the researchers who have specialist knowledge and skills and that it is they who should decide what topics should be researched: they set the research agenda (Oliver, 1992). Yet when this happens, those being interviewed become separate, alienated; they are “used for someone else’s ends […] the person’s actions do not belong to that individual, but to the researcher and the research plan” (Rowan, 1981, p. 93). A positivist model is especially problematic when working with marginalized populations given that the construction of mainstream knowledge excludes their perspectives.

Qualitative research is one way to challenge a positivist model, especially through providing first-hand accounts that serve to deconstruct the normative body as an ableist one and to revise the prevailing narrative about disability and the lives of d/Deaf and blind persons. Thus, it’s not surprising that qualitative approaches can provide a “more rounded, richer picture of disabled people’s attitudes” than quantitative studies (Deal, 2003, p. 907). Qualitative research is a “situated activity that locates the observer in the world. It consists of a set of interpretative, material practices that [transform] and make the world visible” (Denzin & Lincoln, 2005, p. 3). It also recognizes the “need to account for the influence of
the researcher on the data collection and analytical process” (Langdridge, 2007, p. 3).

My qualitative research framework is situated within the field of disability studies; specifically that of disability studies methodology, which emerged out of early scholarship on feminist studies methodology (see Michelle Fine, 1996), emancipatory research (see Michael Oliver, 1992), and disability studies (see Kafer, 2013 and Linton, 1998). Disability studies intersects with feminist, action, and social justice research in its aim to challenge the production and sharing of knowledge – that is, the researcher being in the position of power and knowing more than those being researched. Going one step further, feminist disability studies asks us to consider how race, class, sexuality, religion, nationality, and so on, intersect with the experience of disability (Hammell, 2007; Price, 2012). One of the first research methods utilized within disability studies was that of emancipatory research, which was at one time considered the only honorable way to study participants with disabilities (Oliver, 1992). Inspired by the writings of disabled activists and scholars in the 1980s and 90s, the emancipatory turn shifted conversations about disability away from the medical model to focus on how the person being impacted could upend the environmental and cultural barriers that excluded them from everyday life.

There is no singular approach that characterizes disability studies methodologies. As an interactional model, this methodological practice aims to crip conventional forms of analysis; re-imagine access in qualitative studies; highlight the multiple oppressions disabled people face in their daily lives, especially in relationship to gender, race, and class; and

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1 The philosophy of emancipatory research is one that recognizes the inherent power imbalance in traditional research approaches; this model aims to empower disadvantaged and socially oppressed respondents by giving them a voice for change.
restructure the relations of power (Price, 2012). Working from this framework, the researcher must think about access – which includes the built context of how physical spaces (such as stairs and ramps) and metaphorical spaces (such as attitudes) are created. The researcher must also think about their relationship to disability as well as how they will invite participants to contribute to the representation of the data (Price, 2012). Challenging systemic oppression and returning power to participants prioritizes the needs of disabled people and contributes to knowledge building. Michael Oliver (1992) argues that disability studies research must challenge the social relations of research production, contesting the notion that the researcher is in the position of knowledge. Margaret Price (2012) goes one step further to state that disability studies methodology should aim to “radically reshape the relations of power” (p. 165).

Regardless of the specific methods used in any given analysis, disability studies methodology asks that the researcher critically notice the ways that disability may subtly – or not so subtly – appear throughout participant recruitment, interviews, coding, and final analyses. The researcher must also pay attention to the power shifts throughout the interview – that is, when the researcher has power versus when the interviewee has power and how this dynamic occurs throughout the process (Brinkmann & Kale, 2005; Lukes, 1974).

I have adopted a disability studies framework in my analysis of the lived experience of deaf and blind psychotherapists. In this project, I aim to understand how research methods must be altered to fit the needs of interviewees who present with sensory challenges that may dis-able typical interviewing practices in qualitative research. In utilizing multiple methods of analysis (IPA and autoethnography) within my research framework, I attempt to create an interdependent paradigm that challenges usual assumptions about how qualitative research should be conducted. The rest of this chapter covers my rationale for
using IPA and autoethnography; the specific steps that I used to undertake this study, including an example of IPA coding, is discussed in the next chapter.

2.2 Interpretive Phenomenological Analysis

Phenomenology seeks to understand human experience by illuminating tangible experiential accounts of individual experiences (Finlay, 2009; Langdrige, 2007). For example, a researcher using a phenomenological method might encourage participants to tell stories or draw pictures that highlight their social, historical, and cultural background. Phenomenological “researchers generally agree that [the] central concern is to return to embodied, experiential meanings. [They] aim for fresh, complex, rich description of a phenomenon” (Finlay, 2009, p.1). There are a variety of ways that a researcher can concretely and naturalistically observe the lived experience of a phenomenon. These include Amedeo Giorgi’s descriptive phenomenological psychology, hermeneutic phenomenology, template analysis, and interpretive phenomenological analysis (Langdrige, 2007). Given the nature of my research, a phenomenological approach, especially centered within disability studies, is the best method to explore what my study hopes to capture.

The most common of these two qualitative methods are Giorgi’s descriptive phenomenological psychology and Jonathan Smith’s interpretive phenomenological analysis (IPA). Descriptive phenomenological psychology attempts “as close a translation as possible of [the philosopher Edmund] Husserl’s phenomenological method” (Smith, Flowers & Larkin, 2009, p. 200). In contrast, IPA highlights the limitations of Giorgi’s method. IPA welcomes idiographic accounts in its attempt to understand the individual, and aims for a detailed analysis of each participant’s lived experience rather than global insights. IPA is phenomenological in “being concerned with participants’ lived experience and hermeneutic
because it considers that experience is only accessible through a process of interpretation on the part of both participant and researcher” (Smith, 2010, p. 186). Unlike Giorgi’s method, IPA does not argue for the bracketing of assumptions but recognizes the researcher as part of the data. In this way, IPA pairs well with a disability studies methodological framework in that researcher’s assumptions, preconceptions, and biases about disability are explored alongside the data. Given the complexity and novelty of my topic, IPA is suitable for discovering “the particular situations [my participants face and] how they [make] sense of their personal and social world” (Smith & Osborne, 2008, p. 55). For example, throughout my dissertation I frequently discuss my identity as a researcher with a disability, one that is shared by some of my participants. I interrogate my past, present, and future while also analyzing participant stories. In the next chapter, I discuss the process by which I utilized IPA with my interview transcripts.

2.3 Autoethnography

As a researcher who shares the same disability as some of my participants, I realized that I would be remiss not to include aspects of my own experience, especially if I wanted to conduct a hermeneutic, reflexive analysis of the self – that is, an “interpretation of [my] thoughts, questions, emotions and initial insights” from a disability studies framework (Fleck, Smythe, & Hitchen, 2010, pg. 15). In Claiming Disability, Simi Linton (1998) writes: “Stating that one identifies as disabled or nondisabled calls attention to the absent voice of disabled people in scholarship and illustrates that the reader may tend to make the assumption, although probably not consciously, that the writer is nondisabled” (p. 153). Disability studies scholar Margaret Price (2012) also describes feeling perplexed by the failure of researchers to identify themselves with respect to the topic under study.
Autoethnography is one method by which a researcher interrogates his or her own experiences with respect to the research question. It is not the same as memoir or autobiography; rather, the method requires an analytical and reflexive look at the self in relation to others. An approach that describes and systematically analyzes personal experience in order to understand cultural experience, autoethnography treats the experiences of both the researcher and the researcher as a “political, socially just, and socially conscious act” (Ellis, Adams, & Bochner 2010, para. 1). This method uses “personal experience with a culture and/or a cultural identity to make unfamiliar characteristics of the culture and/or identity familiar for insiders and outsiders” (Adams & Jones, 2011, p. 109). Additionally, autoethnography has its own standards for reliability, validity, and generalizability. Within the context of a disability studies approach, autoethnography works to challenge normative ideas about research, to recognize the connection between the personal and the cultural, and to crip traditional forms of inquiry and analysis.

In their article, Carolyn Ellis, Tony Adams, and Arthur Bochner (2011), frequent contributors to the field of autoethnography, discuss the different forms that autoethnography can take, including narrative ethnographies, reflexive interviews, co-constructed narratives, community autoethnographies, and personal narratives. For my dissertation I have chosen to utilize a hybrid autoethnography – one that draws both from my experience (personal narrative) and that of my participants (community autoethnography) to create a meaningful account of disability within the therapy space, as well as to highlight how my personal experience illuminates the deaf, blind, and therapy cultures.
2.4 Member Check

Across most psychology research studies, the voices of participants with disabilities go unheard. They are often interviewed by nondisabled researchers; their stories get either misrepresented or disseminated into larger data; and their lived experiences go unrecorded. Key to disability studies methodologies is the move from research on disabled people by able-bodied researchers to research with disabled people by disabled researchers. As researchers, we must continuously ask: “Who gets to speak and how? To what extent are we limiting this interaction to match our own abilities as researchers?” (Sunderland, Chenoweth & Matthews, et al., 2015, p. 54). Australian sociological researcher Rea Dennis (2000) raises an important question when she asks, “How can we be sure of authenticity when the very production of the voice, or gathering of the story, may in itself be a form of oppression?” (p. 24).

One way to ensure that results are valid and credible is through doing a member check, a method frequently used in qualitative research to solicit participant insight. According to Susan Doyle (2007), a member check involves:

The [checking] of data, analytic categories, interpretations, and conclusions with members of the stakeholder group(s) from whom the original information was collected; [it is] considered one of the most significant methods within qualitative research for establishing or strengthening the credibility of a study. (p. 889)

The goal of member checks vary widely and may include aspects of the following: to allow participants to confirm, correct, and challenge facts and interpretations (Doyle, 2007); to ensure trustworthiness of data or to preserve authenticity of results (Kvale, 1995); to explore the lived experience of not just participants but also the interviewer both during and after the interview (Cho & Trent, 2006); to neutralize power dynamics among researchers and
participants by inviting participants to comment (Koelsch, 2013); and finally, to possibly create a collaborative and co-constructive process that may lead to social justice change on the part of the participants (and researcher) (Cho & Trent, 2006; Koelsch, 2013). Moreover, the act of involving my participants in the discussion of my interpretations and questions is also “consistent with the hermeneutic cycle, which requires the constant movement between interpretation and the text, or in the case of the member check, a return to interaction with the participants themselves” (Doyle, 2007, p. 895).

Finally, that member checks have not been used widely in research occurring at the intersection of disability studies and psychology further supports the need for its use in this dissertation. I encouraged select participants to share feedback, to disagree, and to offer insights. In the spirit of increasing accessibility, I invited participants to decide how they want to receive excerpts from transcripts, if they would prefer electronic copies or to have them sent in the post mail. I also informed participants that filler words and pauses are the norm in this kind of research and were transcribed to help me interpret underlying meanings. Finally, I encouraged participants to speak openly and honestly about the results and to offer not only their feedback but also their feelings and thoughts about the interview itself and their reflections since that time. In the spirit of emancipatory action research, and of bringing the stories of my participants together, I also invited them to make themselves known to one another.

2.5 Rationale for Mixed Methods Approach

Working within a disability studies framework makes it possible to integrate different analytical methods such that the shared voices of participants – and researchers – with disabilities gets heard. By integrating IPA and autoethnography, and by conducting my
analysis through a disability studies lens, I aim to increase the production of knowledge between participant and researcher as well as participant, researcher, and the larger society. Rather than focusing just on embodied experiences of living with a particular impairment, utilizing a mixed methods approach allows the researcher to consider how the conditions of disablism are imposed by an ableist society.

Moreover, using mixed methods allows for multiple interpretations of results, especially in light of the multiple oppressions that many disabled people face. Writing this dissertation I have frequently paused to ask myself:

Whose questions and concerns are actually addressed, who is the ‘self’ and who is ‘other,’ who discloses to whom, who does the interpreting, who gets to tell the story, what happens to the stories, who benefits from the stories? (Broun & Heshiusus, 2004, para. 51)

These questions can best be answered through an interdisciplinary mixed methods approach.

Yet a mixed methods approach does not come without limitations; for one, utilizing multiple methods across a large data set can result in a weak or rushed analysis. Additionally, when there is only one researcher looking at the data, as was the case here, it is not uncommon for the researcher to be biased or even confused about what they are interpreting, which can bring up questions of validity, generalizability, and reliability. Having more than one researcher looking over the data can reduce bias through a co-created dialogue about the codes and themes. As Alison Weardon and Joanna Brocki (2006) point out, even though IPA is largely accessible, “authors do not always explicitly recognize either the theoretical preconceptions they bring to the data or their own role in interpretation” (p. 97).

Autoethnography is also not without its limitations, specifically the author’s use of
anecdotal evidence as the subject for analysis. For example, some researchers may inadvertently participate in extracting data to only show the aspects of themselves that fit with pre-existing expectations about the research (Ellis, Adams, & Bochner, 2011). I have tried to avoid this by speaking openly about the struggles I faced both personally and professionally during the writing of this dissertation. Another critique of autoethnography is the use of emotion (as being a subjective plea) as well as ethical concerns in writing about others. Still, these limitations are based on a positivist understanding that knowledge production is limited and that emotion is not a site of meaning making, both of which are false. There is no such thing as an unbiased standpoint, which disability studies, along with feminist and critical race theory, has shown over the last several decades (Haraway, 1988). In fact, the limitations that researchers commonly describe when using IPA and/or autoethnography are often simplistic and reductive of the complexities that arise when doing disability studies research.
Chapter 3
Data Collection and Steps Toward Analysis

3.1 Introduction to Method

This chapter describes how I selected and interviewed my participants, coded the data through a program called NVivo, used the qualitative method of interpretive phenomenological analysis (IPA) to determine the different themes, integrated autoethnographic method to reflect on my own experiences, and followed up with participants using a member check.

3.2 Participant Selection Criteria, Recruitment, and Demographics

Participants for this qualitative study met the following criteria: at the time of interview they were therapists-in-training or licensed therapists; they were currently seeing clients; they presented with a visible sensory disability (i.e., blindness or deafness); they identified as disabled; and they were available for face-to-face interviews or distance interviews via Skype, Google Chat or some other talk program. In order to richly capture the lived experience of disability, I wanted participants to be actively practicing psychotherapy at the time of interview; I believed that as practicing therapists they could best speak about interactions with current clients.

Initially I thought I might focus on a variety of visible disabilities, including mobility impairment, wheelchair users, and so forth as well as blindness and deafness. But early on in conceptualizing this project I realized that I wanted to focus specifically on just blindness and deafness. Unlike non-sensory disabilities, when the therapist presents with a significant impairment in one of these senses the nonverbal dynamic between client and therapist is
inevitably impacted, as well as the intricate ways in which they communicate. Additionally, given my own deafness, I thought that a rich account of my own experiences might complement and contrast those of the participants, especially because I was relying on interviews after the fact rather than live here-and-now observations with my participants and their patients.

I interviewed only those participants who stated they identified as having a disability on the screening form. Some participants identified their disability as being part of a cultural group (e.g., Deaf Culture) and others simply stated it was a sensory disability. In my introductory letter to participants I stated that d/Deaf participants should be working with hearing clients. I explicitly stated that I was not looking for Deaf therapists that worked solely with Deaf clients, as the phenomena of disability itself changes in this context – many culturally Deaf people do not see their deafness as a disability but rather a social difference (“Deaf Gain”) that contributes to the greater good of society. If someone identified as both culturally Deaf and also part of the hearing world and worked with hearing patients, they were included.

While I preferred to conduct interviews in person (given the likelihood of a stronger

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2 “Deaf Gain” is a term coined by members of Deaf Culture; it rejects the notion of hearing loss as an impairment and instead focuses on what Deaf people have to offer and contribute to the greater society. According to Bauman and Murray (2014, para. 8), “Deaf Gain asks the question: is the world better off with Deaf people and their signed languages, or should they be diminished to the point of extinction? Is the audiological status of deafness worth preserving or should it be eradicated? What would society lose if it were to do away with hearing loss?”
I also wanted interviews to be accessible and comfortable for my participants, so I offered a variety of formats, including online chat, online video, and email. Increasing access to different types of interview setups also falls in line with a disability studies framework, although it does require “deep changes to qualitative methods and assumptions” (Price, 2012, p. 166). I conducted six-in-person interviews (all recorded with audio and four with both audio and video), five interviews via Skype (text and audio recording), and three interviews via email.

Participants were sought out online with the exception of one participant who was referred to me by a former colleague. I wrote a letter (Appendix A) introducing myself, describing the nature of my study, and what I was expecting in terms of participant criteria, time, and effort. This letter was posted to a variety of educational listservs, including APA and disability studies listservs, and social media pages. Due to my initial concern that I might not find enough participants, as well as my desire to make interviews accessible, I did not limit my email to a particular geographical region. Additionally, I reached out to various counseling centers across the US that had disability studies programs.

Participants were then screened using a series of questions inquiring about their credentials, training experience, disability, clientele, interest in study, and preferred interview method. I asked the following questions in my initial email (also found in Appendix B):

1. Please state your gender and ethnic background.

2. What is your degree (e.g., MSW, PhD, MA, etc.)?

3. Do you work in academia or identify as an academic scholar?

4. How long have you been practicing therapy? If you are in a training program or pre-licensed, please state how many years you have worked with clients.
5. Are you currently providing psychotherapy to clients individually, in a group setting, or both? Please describe.

6. Do you identify as a person with a disability? Please describe.

7. Do you consider yourself to have more than one disability? Please describe.

8. If you identify as blind, are you currently providing psychotherapy to sighted clients? If you identify as d/Deaf, are you currently providing psychotherapy to hearing clients? If not, have you worked with this population in the recent past?

9. Do you need accommodations in order to conduct a face-to-face or online interview? Please describe.

10. Do you have a preference as to whether we meet face-to-face or online, and do you have a preferred location for the interview?

Once I had identified several participants, I scheduled in-person interviews from June through August of 2014. Interviews conducted via Skype continued through September 2014. Participants are referred to by pseudonyms.

Fourteen participants were interviewed, although only thirteen are represented in this dissertation as one person later withdrew from the study: two male and ten female licensed psychologists and social workers and two female graduate students in clinical psychology. Six therapists identified as hard-of-hearing or d/Deaf and eight identified as visually impaired or blind. I conducted six interviews face-to-face and the remaining over Skype video, Internet chat, or email. The following table highlights the participant demographics and background information (minus the participant who withdrew). All names and details have been changed to protect identifying information.
<table>
<thead>
<tr>
<th>Name</th>
<th>Degree/Specialty</th>
<th>Type of Interview</th>
<th>Years in Practice</th>
<th>Workplace</th>
<th>Disability Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Octavia”</td>
<td>PhD, general, inpatient populations</td>
<td>Face-to-Face</td>
<td>8+</td>
<td>Hospital, Academic Supervision</td>
<td>blind</td>
</tr>
<tr>
<td>“Alex”</td>
<td>PhD, general, community and college populations</td>
<td>Face-to-Face</td>
<td>20+</td>
<td>UCC</td>
<td>blind</td>
</tr>
<tr>
<td>“Nadine”</td>
<td>PhD, general, students</td>
<td>Face-to-Face</td>
<td>20+</td>
<td>UCC</td>
<td>blind</td>
</tr>
<tr>
<td>“Jaime”</td>
<td>PhD, general psychology</td>
<td>Face-to-Face</td>
<td>30+</td>
<td>Private Practice, Consulting</td>
<td>deaf</td>
</tr>
<tr>
<td>“Sophia”</td>
<td>PhD, college students</td>
<td>Face-to-Face</td>
<td>20+</td>
<td>UCC, Academic</td>
<td>deaf</td>
</tr>
<tr>
<td>“Grace”</td>
<td>PhD Student</td>
<td>Skype</td>
<td>4+</td>
<td>Trainee at Psychology Clinic</td>
<td>hard-of-hearing</td>
</tr>
<tr>
<td>“Anna”</td>
<td>PhD, adults, couples</td>
<td>Skype</td>
<td>30+</td>
<td>Private Practice, UCC</td>
<td>d/Deaf</td>
</tr>
<tr>
<td>Name</td>
<td>Profession</td>
<td>Platform</td>
<td>Duration</td>
<td>Organization</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------</td>
<td>------------</td>
<td>----------</td>
<td>--------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>“Brenda”</td>
<td>LCSW, deaf</td>
<td>Skype</td>
<td>30+</td>
<td>Mental Health Agency</td>
<td>deaf</td>
</tr>
<tr>
<td></td>
<td>children and adolescents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Bella”</td>
<td>LCSW, adults</td>
<td>Skype</td>
<td>20+</td>
<td>Private Practice</td>
<td>blind, mild hearing loss</td>
</tr>
<tr>
<td>“Ellen”</td>
<td>PhD, children</td>
<td>Google Chat</td>
<td>12+</td>
<td>Mental Health Agency</td>
<td>deaf</td>
</tr>
<tr>
<td>“Melissa”</td>
<td>International therapy degree, Gestalt therapy</td>
<td>Email</td>
<td>11+</td>
<td>UCC</td>
<td>blind</td>
</tr>
<tr>
<td>“Jake”</td>
<td>LCSW, inpatient</td>
<td>Email</td>
<td>13+</td>
<td>Hospital</td>
<td>blind</td>
</tr>
<tr>
<td>“Donna”</td>
<td>PhD, general</td>
<td>Email</td>
<td>7+</td>
<td>Government Agency</td>
<td>hard-of-hearing</td>
</tr>
</tbody>
</table>

### 3.3 Interview Data Collection and Method of Analysis

Interviews began with a review of the consent form (Appendix C). If the interview occurred via Skype, email, or an online chat program, I asked the participants to sign and return the consent form to me in advance of the interview start time.

Interviews with Octavia and Sophia utilized the video-recorder provided by my department. It was not feasible to video-tape interviews with Alex, Jaime, and Nadine due to location of interview as well as my travel schedule. Interviews with Grace, Anna, Brenda, and Bella were video-recorded using my computer’s screen capture program, an application that can capture interviews as they are happening on Skype. Interviews with Melissa, Jake,
and Ellen occurred via email and were not videotaped. All interviews, minus the emailed interviews and the interview that occurred over Google Chat, were audiotaped for transcription purposes.

My interview questions were both open-ended and specific, targeting a variety of topics around disability and psychology, including support in graduate school, self-disclosure methods, training, and the participant’s understanding of how disability impacted the therapy process. I asked the following questions (also in Appendix D):

1. What are the major challenges you face in being a therapist?
2. What are the most important experiences that have shaped your development as a therapist?
3. How has being deaf [or blind] impacted your work as a therapist?\(^3\)
4. How has being deaf [or blind] influenced your relationship with your clients (e.g., therapeutic alliance)? Please tell me about a specific time when you have felt this impact.
5. How have you self-disclosed your disability to clients and responded to client’s questions about your disability? Please tell me about a time when you’ve self-disclosed that feels particularly meaningful or challenging to you.
6. Please tell me about a time you had strong feelings about your disability in response to a client’s comment or experience.
7. How has your disability influenced the ways by which you listen to and understand your clients? Please tell me about a specific instance that feels particularly

\(^3\) I changed the wording depending on the client’s preference (e.g., preferred to go by hearing-impaired rather than deaf or visually-impaired rather than blind).
meaningful or challenging to you.

8. How has your disability influenced your choice to become a therapist? What about your theoretical orientation?

9. How have your experiences in supervision and graduate training been impacted by your disability? How do you talk about your disability to others when they ask about it?

I attempted to stick as closely to the script as possible, while also being aware that the lived experience of each participant required that I be flexible in changing the script and interview structure as needed.

Following discussion of the consent form, I took a moment to set up the video and/or audio recording. I encouraged the interviewee to make themselves comfortable and engaged in pleasantries to further rapport building. As participants spoke, I asked questions either for clarification or because I did not hear something. In-person interviews tended to run longer due to the set up time as well as the fact that interviewing face-to-face often led to greater rapport and deeper conversations.

Interviews using Skype, Purple Communications, or Google Chat often began with a lot of missteps, largely due to Internet connectivity issues on one side or the other. If the video could not be established or if the screen was frozen, as was the case for some of my interview with Grace, we relied on text-based communication (e.g., typing in the chat box below the video screen). This was effective in that it allowed me to get everything the participant was saying, as lipreading over a video screen can be difficult. Even if the video picture was clear for the entire duration of the interview, some text-based communication was needed due to my difficulty in lipreading via screen. With respect to interviews that occurred over email, once I had received the consent form, I then sent my participants the
list of questions. Any follow up questions, which I tried to keep to a minimum, were specific and brief in order to elicit more free association from participants.

All audio/video-recorded interviews were transcribed by Christy Azzarello, a real-time captioner who has been working with me since my first year in graduate school at Duquesne University. For interviews that occurred online, I compiled and edited the transcripts for the purpose of analysis.

**Method #1: IPA Step-by-Step.** I initially read each transcript without making any notes, as I wanted to get a feel for each interview and my overall project. During this process I took care to pay attention to the themes implicitly stated in my questions as well as the themes my participants deemed important, such as challenges faced outside the therapy room. I also noted differences in themes between deaf and blind participants.

Once I had completed an initial reading of the transcripts, I imported transcripts into a program called NVivo, a software platform for qualitative researchers with large amounts of data to code. This program allowed me to upload all my interview transcripts into a folder and code by highlighting an excerpt of text and creating a new theme (called “node” in NVivo). I could also annotate the text by highlighting the selected passage and making a note in the right hand margins.

In determining what and how often to code, I turned to Smith, Flowers, and Larkin’s (2009) *Interpretive Phenomenological Analysis* as a guide. The writers recommend reading through for explicit and implicit themes that appear on a line-by-line basis and also to make note of linguistic themes, interviewer reactions, and tentative interpretations. Using NVivo, I created nodes under the heading “Emergent Themes” and another under “Exploratory Comments.” The emergent themes column consisted of themes noted in a few words that applied to an entire passage, as seen in this example from Alex’s transcript:
I: So can you tell me a little bit about why you went into psychotherapy?

A: Sure. Complex. Probably many factors, my life didn't necessarily initially go in this direction at first. But at the same time it kind of did. I think a lot of the factors had to do with the reality of my disability and I was diagnosed with a rare form of cancer when I was two years old and lost most of the sight in my right eye and all the sight in my left eye.

The italicized section was then coded as “disability impacted career choice,” which later became a recurring theme across many interviews.

The exploratory comments column consisted of my initial impressions and thoughts about each line of text on linguistic, descriptive, and conceptual levels, as seen in this example, also taken from Alex’s interview: “I’ve heard people yell out the window also at me that he's not really blind, he's faking it. You know, I’ve had people laugh at you, people honk the horn at you. Yell at you” (Laugh). This passage was first coded under emergent themes as “discrimination” and “misconceptions about blindness.” But reading it again, more introspectively, I wondered about the role of humor as a defense against possibly anxiety or painful feelings arising from the memory of this event. Under the exploratory comments node, I coded “humor as defense.”

NVivo was also helpful in that it allowed me to make multiple sub-themes within a primary theme, so that I could cluster together similar threads. This process is not unlike the traditional method by which researchers color code across different themes or move sheets of paper around under major thematic headings. An example of NVivo in action is provided below:
After I coded each interview with emergent themes and exploratory comments, I then clustered together similar themes. For example, the superordinate theme “Challenges” included subordinate themes, “General Challenges” and “Challenges as a Disabled Therapist.” The NVivo program made it possible to see which interviews were coded under a particular theme, thus saving me the work of having to move stuff around. Throughout this process, I frequently asked myself: “What is the person trying to achieve here? Is something leaking out here that wasn’t intended? Do I have a sense of something going on here that maybe the participants themselves are less aware of?” (Smith & Osborne, 2008, p. 55).

Following my first round of coding with all interviews, I took a break of about two weeks before returning for a second round of coding. This break felt necessary in order to get some space from the data and to ensure I was not imposing my own beliefs on the material. Upon returning to the data, I attempted to capture themes that were not explicitly
obvious. Drawing from the recommendations put forth by Smith, Flowers, and Larkin (2009), I also organized emergent themes in terms of the temporal moment where they occurred, noted the frequency with which a theme occurred, and noted the function of the theme within in each transcript. When material was coded in more than two places (as was often the case), I made a decision about which code was primary and which was secondary. I also attempted to move responses “to a slightly higher level of abstraction and [invoked] more psychological terminology” (Smith & Osborne, 2008, p. 68). For example, comments that were initially coded under “therapist’s view of self” were later coded to reflect underlying mixed feelings about embodying or rejecting the supercrip narrative.

Throughout the process of coding, I frequently asked myself: what does this theme mean to my overall dissertation? Why might participants find this action or belief useful? Deaf researcher and English professor Brenda Brueggemann reminds us that the search for concrete answers or themes is not the goal of humanistic research; rather one is better served by guiding questions, such as “Which of our representations give us voice, make us silent?” (Brueggemann, 1996, p. 34). This perspective that seems especially important when doing research with disabled populations. My final coding list is below (also seen in Appendix F). The number listed after the major and minor themes indicate how many unique times it was mentioned throughout interviews.

<table>
<thead>
<tr>
<th>Challenges as a Disabled Therapist [14]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodations [4]</td>
</tr>
<tr>
<td>Challenging as a Disabled Therapist [14]</td>
</tr>
<tr>
<td>Accommodations [4]</td>
</tr>
<tr>
<td>Challenges [14]</td>
</tr>
<tr>
<td>Challenges in General [7]</td>
</tr>
<tr>
<td>Attachment Issues with Patients [1]</td>
</tr>
<tr>
<td>Bracketing Self [2]</td>
</tr>
<tr>
<td>Client Resistance [2]</td>
</tr>
<tr>
<td>Ethics/Institutional Rules [3]</td>
</tr>
<tr>
<td>Keeping up with Research [1]</td>
</tr>
<tr>
<td>Time Limited Model [2]</td>
</tr>
<tr>
<td>Time Management &amp; Self Care [2]</td>
</tr>
<tr>
<td>Challenges as a Disabled Therapist [14]</td>
</tr>
<tr>
<td>Accommodations [4]</td>
</tr>
</tbody>
</table>
ADA [3]
Anxieties in Relational Dynamic with Others [6]
Impact of Colleague and Client Assumptions [11]
Client Populations & Therapy Modalities [9]
Discrimination [5]
Exhaustion Related to Lip-Reading & Impact on Self [5]
Isolation & Lack of Community [8]
Loss of Self-World [3]
Implications of Passing/Not Passing [9]
Self-Esteem Building Responses to Challenges [13]

Does Not Personalize [2 participants]
Impact of Disability on Therapy Processes [14]
  Clients Use of/Response to Disability [11]
    Clients Response as Diagnostic for Therapist [4]
    Clients as More Understanding than Colleagues [3]
    Clients Belief in Therapist Ability to Empathize [4]
    Clients Belief in Therapist Ability to Overcome [4]
    Helping Behaviors Displayed by Clients [7]
    Unique to Blind Participants: Clients Desire to “Hide” from Therapists [4]
  Effects of Disability on Therapy Alliance/Relational Spaces [11]
  Therapist Experiences Disability as Fluid [3]
  Power Dynamic Struggles Between Client & Therapist [5]
  Psychodynamic Processes [11]
    Client Projections about Disability & Impact on Therapy [8]
    Transference-Countertransference around Disability [11]
  Does not have an impact [3]

Therapist Process of Self-Disclosure [13]
  Client Response to Self-Disclosure [10]
  Styles of Self-Disclosure on Patient Reactions [12]

Therapist Use of Disability [13]
  Body as Therapeutic Tool [6]
  Dog as Healing or Special [2]
  Facilitate Client’s Understanding of Self [4]
  Unique to Deaf: Positive Impacts of Mishearing Clients [2]
  Modeling/Psychoeducation [10]
  Unique Listening Skills/Non-Verbals [12]

Importance of Time on Self-Confidence [5]
Negative Impact of Disability on Therapy Career [1]
Positive Impact of Disability on Therapy Career [8]
Therapist View of Self [12 Participants]
  Impact on Beliefs [10]
    Accomplished [6]
    Anxieties about Success [3]
    Recognizes Limitations [5]
    Sees Self as Super Crip/Wounded Warrior [4]
    Disability as Having Personal Value [2]
    Must Fight Systemic Oppression [1]
    Minimization of Disability [4]
Impact on Self-Esteem [10]
Effects of Positive/Negative Training Experiences [14]
Growth of Colleagues/Classmates [7]
Effects of Negative/Mixed Support [10]
Effects of Positive Support [12]
Therapist’s Growth [2]
Non-Verbals on Interview Dynamic/Interviewee Underlying Feelings [10]

Following completion of the detailed steps above, I then wrote up the Major and Minor Table of Themes with corresponding excerpts (Appendix G) as well as the individual themes for each participant (Appendix H). Smith, Flowers, and Larkin (2009) point out that when a study is large it can be hard to effectively manage data; thus, paying close attention to how many times a theme recurs is important in creating the results chapter.

**Process of Writing up IPA Results.** Rather than providing an excerpt from every interview transcript illustrating the theme under review, I arranged the results chapter to focus on just two or three poignant examples to avoid redundancy and a plethora of quotes. My criteria for choosing extracts to represent in the results chapter are as follows: they were rich with emotional complexity, excited my imagination, or illustrated links between different themes. Occasionally, I included atypical extracts to illustrate contradiction or complexity. I also included a few themes that were endorsed by only a small number of participants rather than the majority (e.g., 2/3).\(^4\) I am aware that this choice goes against traditional IPA methods, but my project’s content demanded a slightly different orientation – one that crippled normative approaches to qualitative analysis. In addition, given the lack of

\(^4\) Appendix H provides a more holistic look at each participant's major themes, as well as their thoughts and feelings about disability. I also include some of my own notes throughout this appendix.
representation by disabled participants in the psychology field, I wanted to include as many voices as possible.

**Method #2: Autoethnographic Analysis.** My autoethnography was written throughout the process of conducting interviews and coding the results. Given that my use of autoethnography and IPA are informed by each other, in that I am a researcher who shares the same disability as many of my participants, critically reflecting on my own experiences throughout the writing of this dissertation felt imperative in making key connections between participant themes and my own, as well as calling attention to differences.

I began my autoethnography by free writing about those experiences in my life that felt important to my overall dissertation project: my upbringing, my personal journey toward becoming a therapist, and moments with patients that seemed particularly meaningful with respect to my own understanding as a deaf clinician. I then reviewed themes derived from my analysis, reflecting on similarities and differences between my experiences and that of my participants. After free writing about many different examples, I chose to include those that seemed most relevant to the material at hand. In deciding what to keep and cut from my autoethnography, I frequently asked myself: “How can I invite readers [...] to use my stories and experiences [and that of my participants] for their own sense making?” (Adam, Jones & Ellis, 2015, p. 39).

As described in the literature review, there is no one set way to write an autoethnography. Doing so is an intense personal journey that requires a critical look at one's motivations for including their own experiences and how such experiences compliment, challenge, and do justice to participant experiences. Autoethnography is a personal journey; thus, readers interested in autoethnography should not attempt to replicate my process but
to find their own process.\textsuperscript{5}

\section*{3.4 Member Check Procedure}

After I completed my analyses, I selected participants to take part in a member check. My logic for choosing only select participants included a number of reasons, mostly centered on my decision to forgo individual analyses and focus on the overall results, which resulted in less of a need for member checks. Additionally, my face-to-face interviews were often the strongest and elicited rich data; thus I had more to say about these interviews and wanted feedback from participants. I made this choice while being aware that choosing only select participants flew against the face of a disability studies framework, one that would argue for all participants being included. I discuss the ramifications of this choice in greater depth in the reflexivity chapter.

Select participants received an initial email inquiring if they were interested in participating in member check. Those who were interested received a follow up email containing a list of questions to consider and their individual analysis. One participant chose to withdraw after member check; the implications of this interview are also discussed in the reflexivity section. Documents about the member check can be found in Appendix E.

\section*{3.5 Rationale for Participant Data Collection}

During data collection, power of information, knowledge, and even of vulnerability

\textsuperscript{5}Tony Adams, Stacy Jones, and Carolyn Ellis’ \textit{Autoethnography: Understanding Qualitative Research} (2015) offers an excellent overview on how to undertake this method as a stand-alone study or even within a larger research project.
shifts back and forth between interviewers and interviewees; thus at any given time there is always an asymmetrical power relation occurring within the interview (Brinkman & Kvale, 2005). For example, as a researcher I had power in terms of designing the questions but participants had the power whether to answer forthrightly or to divert. From a disability studies perspective, such power imbalance is necessary in order to further highlight how people with impairments are oppressed by a society that continues to disable them – as well as how participants might be oppressed within the interview itself by the researcher’s agenda, even if both share the same disability, a topic further discussed in the reflexivity chapter.

Only recently have researchers begun to consider the divergent communication needs of their participants; it is even more rare for a researcher to fully understand that what is technologically accessible for some may pose serious problems for other disabled users (Best & Butler, 2014). For instance, Skype does not work for everyone just because it offers both talking and type functions. As Paul Jaeger (2006) asserts:

A site may be completely inaccessible for users with one type of disability and fully accessible for users with a different type of disability. Even within the same type of disability, persons with one level of severity of a disability may have different accessibility issues than persons with a different level of severity of a disability. (p 171)

Additionally, many researchers often assume that:

A face-to-face, orally driven setting is the ‘natural’ or ‘normal’ way to proceed” [and] email, instant-message or video communication [is] framed as a compensatory measure, one that is being used because of some imagined deficit in the interviewer or interviewee. (Price, 2013, p. 3)

Throughout my interviews I struggled with my own bias that face-to-face would result in a
“better” interview given my unique attunement to non-verbal dynamics, while also recognizing that having multiple forms of interview setups would increase accessibility. My concern that I had not been well trained in doing interviews via alternative forms of technology, alongside my general tentativeness with technology, also added to my bias. Still, I chose to collect data through multiple forms of media to increase participant recruitment and accessibility.

Gathering data would not have been possible had I not assessed my own readiness before each interview. The phenomenological researcher, Les Todres (1999) argues that how researchers ask questions can influence how the participant chooses to respond. For this reason, I often took a few minutes before each interview to meditate and free-write about anxieties. In only one case was it difficult to ensure that the environment would not be disruptive – this particular interview took place in a hallway at a busy conference at the interviewee’s request. That said, it is important to note that one’s experience of what is disruptive differs given how one interprets the world through the senses.

3.6 Researcher Data Collection

In addition to gathering participant data, I also had my own data to collect throughout the various stages of the dissertation process. Before my first interview, I attempted to answer my own interview questions in order to get an embodied and intellectual sense of what it might be like for my participants to answer, and throughout the interview process I maintained a reflexive journal in order to unearth and reflect upon my own preconceptions, fears, and desires, and to grapple with my identity as a disabled researcher. Rather than trying to bracket my thoughts, I wanted to think about how I might hold them in mind while doing the interviews. Qualitative researcher and psychologist Russ
Walsh (1995), argues that “bracketing […] can no longer be seen as setting aside assumptions to provide a clear view [but] instead […] becomes a process of explicating one’s approach as inexplicably part of the observed phenomenon” (p. 336). Throughout the dissertation process I frequently asked myself, “How might I be imposing my experience onto my interpretation of my participants’ experience?”

In order to better access the lived experience of each interview, I took notes during the process of coding the interviews. I also spent a few weeks listening to each tape (while following along with the transcript, coded by Christy) and watching videos in between rounds of data coding. Immersing myself in what I could hear of the participant’s voice and my own, and carefully attending to the non-verbals on the video, allowed me to become fully immersed in the multiple ways by which I could understand and analyze the data. Moreover, because there was a long time lapse between the interviews and data analysis (due to internship interviews), by watching the video and listening again to the audio I was better able to recall the feeling of being present in each interview rather than just relying on my written notes.
Chapter 4

Results from IPA Analysis and Member Check

“I am often struck by how similar we all are as human beings in our need for a sense of belonging, to be understood, loved and accepted.” – Melissa

4.1. Interpretive Phenomenological Analysis: Introduction

This chapter begins with a brief description of each participant. This is followed by a discussion of the challenges my participants faced as a therapists with disabilities, which then dovetails into topics around development of the therapist’s identity, self-disclosure styles, the relationship between disability and therapeutic alliance, and transference and countertransference with regard to disability. I also present the results of the member check follow-up. I interweave discussion about IPA results throughout this chapter; discussion of results related to disability studies is discussed in the next chapter, and the theoretical implications and directions for future study are taken up in the final chapter.

Original textual excerpts are indicated by quotation marks and are followed by the number of the meaning unit to which the excerpt corresponds. MU1 refers to the first designated meaning unit in the Master Table of Themes List (Appendix G). Meaning units within the Individual Participant IPA Themes (Appendix H) are designated by the first initial of the participant’s name followed by the number. For example, O1 refers to the first designated meaning unit within Octavia’s transcript. Pauses in speech are indicated by an ellipsis and omission of text for clarity is indicated by three periods within a bracket. In the case of interviews conducted via e-mail or online chat, smiley face icons and exclamation points frequently appear.
4.2 Cast of Characters: An Inside Look at Each Participant

This dissertation encompasses the different stories of thirteen participants. The benefit to having such a large participant sample is bearing witness to a variety of rich stories and experiences; the downside is that some voices get lost in the shuffle. For this reason, rather than having just a brief demographic table of participant characteristics, as provided in the previous chapter, I wanted to offer a more lengthy description of each person who appears in the following pages. When not all voices get the same quantity of discussion (due to the nature of the study design as well as participant disclosure), offering an in-depth portrait seems imperative when thinking about how the voices of disabled people do not often get heard in mainstream psychology studies. Additionally, in describing the comportment and personality of each participant, I hope to bring their stories to life in the results chapter. All names and identifying information have been changed to protect participant identities.

Octavia

“I feel like I’m more of a woman in your presence than in anyone else’s” – Transgender patient to Octavia

A blind clinical psychologist working at an inpatient hospital in a big metropolitan city, at the time of interview Octavia provided individual, family, and group therapy to both the sighted and visually impaired. She treated patients aged 18-97 across all clinical spectrums and from a variety of ethnic and cultural backgrounds -- “literally the whole gamut.” Octavia defined her orientation as psychodynamic, though she also drew from other approaches to meet the individual needs of her patients. She became cortically blind in 2000 due to complications from labor that resulted in a brain injury; she experienced other challenges from this injury, including processing delay, spasticity, and balance difficulties. Octavia has been practicing psychotherapy for over eight years. She also identifies as black.
I interviewed Octavia in person, using video camera and audio recording. Dressed in a navy blue suit and heels, Octavia seemed relaxed and at ease. Right away, I felt comfortable with Octavia, and attributed this feeling to her experience as a supervisor. She spoke clearly, stayed on topic, and responded to my questions with thoughtful vignettes. She also took care to fully explain her disability, offered me advice about internships, and was not afraid to tell me if I misunderstood the meaning of something she had said; thus, our dynamic had hints of a supervisory-mentee relationship.

The themes that resulted from Octavia’s story suggest that becoming blind has invited new (albeit challenging) ways for her to experience the world with curiosity and openness. That is, much of her process of becoming a psychologist, believing in herself, and trusting in her skills as a therapist stemmed from acceptance of her impairment and the ways she continued to challenge the social conditions of disability. Rather than being a totally disabling condition, the lived-experience of blindness was both a way of being and a tool in her therapy work. Octavia stated: “Before my brain injury, […] I had taken coursework in psychology, [but] I didn’t value what was actually happening in those processes. And so to be forced into [becoming a psychotherapist] opened up my eyes.” Octavia gained a sense of accomplishment from balancing multiple duties, including helping interns “find their voice” and helping patients who have “lost the will to live”; she described both of these duties as “unbelievably rewarding.”

Nadine

“I’ve always had an interest in trying to figure out how people worked, you know?”

A counseling psychologist employed at a University Counseling Center (UCC), Nadine became legally blind at age 16. At the time of interview, she provided individual psychotherapy to university students, working primarily from a CBT perspective. She also
ran outreach programs and took part in diversity mentoring on campus, a hugely enjoyable aspect of her job. A PhD graduate, she had been practicing counseling psychology for 28 years.

Our interview took place at a psychology conference that we were both attending. Petite with short blond hair and a big smile, Nadine greeted me with her service dog at the arranged meeting place. She stated that she would prefer to interview outside of the room where she was scheduled to present next so she wouldn’t be late.

The major themes that came up in Nadine’s interview include a strong sense of personal responsibility around problem-solving skills and the role of her dog in her understanding of herself as a clinical psychologist. Throughout the interview, Nadine stressed the importance of solving her own difficulties, as portrayed in the following excerpt from internship year:

I just talked to them and said, ‘Here are the accommodations I need,’ and I talked about my role in problem solving, and this is what we can do. So it’s not that I expected them to make accommodations. I really had to problem solve and advocate for myself and so that's my spirit in teaching clients to advocate.

Nadine modeled for her patients self sufficiency and problem solving skills. She was less interested in how disability impacts transference and countertransference and more interested in seeing her impairment as a positive vehicle by which she could educate, inform, and model healthy coping skills to those she treats.

Alex

“The identity of having a visual disability – it’s a very odd place to be.”

At the time of interview, Alex was the director of a UCC; he earned his PhD in Counseling Psychology. He became blind after the age of two due to retinoblastoma (cancer
on retinas). Alex provided individual psychotherapy to mostly nondisabled university students through his campus job and with community members in his private practice. He described his theoretical orientation as “integrative,” utilizing CBT, insight, person-centered, and interpersonal approaches in his work with clients. “Rolled into [his orientation],” was a “diversity and multicultural component.” He became a psychologist after pursuing degrees in other fields. He sought a degree in this field because he recognizes that maybe he could have “benefitted from some psychological services” as a child due to his disability.

I interviewed Alex face-to-face in a conference room of a hotel. Our interview lasted approximately 70 minutes and was audio-recorded for transcription purposes. Tall and thin, with light brown hair and a kind face, Alex walked with a cane for spatial navigation. Throughout the interview, Alex thoughtfully engaged with my questions, offered a critical analysis of his own understanding of his therapy work and disability, and was willing to repeat when I didn’t hear him. As a therapist, Alex was transparent and open about his strengths and limitations. He continually worked to accept his disability as well as to challenge stereotypical views that he had “overcome” and thus should be seen as a hero. That is, while he was consciously aware of how his visual disability positively impacted the therapeutic dynamic, he did not see himself as holding special skills and did not attribute his success to his disability. Of all my participants, Alex most often discussed the downsides to having a visual impairment. For Alex, accepting disability (and all its complexities) also meant accepting experiences and feelings that could be simultaneously isolating and empowering. In our meeting together, I very much felt a calm presence emanating from Alex – he seemed at home in his body and the world around him, a bit like a meditative guide.
Grace

"Why can’t the rest of the world be [more accepting] like my patients”?

At the time of the interview, Grace was a doctoral student in counseling psychology and had been seeing clients for four years in individual and group psychotherapy. She identified as Eastern European and hearing-impaired; she used hearing aids. Grace labeled her orientation as “multicultural, feminist, Gestalt, and person-centered.” She worked with university students and community members at her school’s graduate clinic, including four long-term clients.

I interviewed Grace via Skype after meeting her at a national feminist psychology conference. Our conversation lasted a little over an hour. Grace laughed throughout the interview and didn’t seem too perturbed by the connectivity issues. I felt connected to Grace given our respective journey throughout graduate school and similar experiences with hearing loss.

Many of Grace’s struggles seemed related to accommodation issues at her university and clinic, needs that were not really understood by her faculty and department because she could pass as hearing and seemed to do “well enough.” Because Grace devoted much time and energy to fighting for accommodations, she experienced the actual therapy with patients as a refuge, a place where positive experiences happened; she frequently stated that she did not experience any negative or confusing experiences with clients with respect to her deafness.

Jaime

“You do so much more to get to the starting line [...] that’s why it’s so important for…self care.”

A psychologist in private practice, Jaime straddled both the hearing and culturally Deaf worlds. She was diagnosed at 13 with acquired deafness but didn’t learn ASL until she
was in college. Jaime defined her orientation as psychodynamic and, at the time of interview, provided individual and couples psychotherapy to individuals who were hearing, hard-of-hearing, and culturally Deaf. I interviewed Jaime in her private practice office in a busy metropolitan city.

Right away, I was struck by how warm and receptive Jaime was to being interviewed. Throughout our conversation, she wove a tapestry of both traumatic and uplifting experiences that highlighted her entry into psychotherapy and ongoing practice. From a history of family tragedy to a career choice that had also served as a healing process from loss, from disparaging remarks about her abilities from hearing superiors to her ongoing success in private practice, from the difficult decision to get cochlear implants to her ongoing struggles finding her place within the hearing and Deaf communities, Jaime’s story was one of resilience, courage, and curiosity. The major themes that emerged from our interview include: influence of childhood experiences on therapist identity, ongoing fluidity (and possible uncertainty) with deaf identity, and disability as a positive experience in terms of transference, countertransference, and self-reflection.

From the very beginning of our conversation, Jaime was vulnerable, open, and curious about my questions and her own understanding of herself and worldview. When asked about her desire to become a psychotherapist, Jaime spoke about family dynamics and loss of a family member. She credited her experiences in childhood to her work with traumatized patients, though at the time of interview she no longer focused exclusively on that population.
Sophia

“So much about disability is internalized, and it really takes a while to separate from that [and recognize] the true limitations.”

At the time of interview, Sophia was a psychotherapist at a UCC in a small city on the east coast. She identified as “audiologically deaf,” Jewish, and an academic. She provided individual psychotherapy to mostly hearing students and had been practicing for 28 years. I interviewed Sophia at her office; our conversation lasted approximately 60 minutes and was video- and audio-taped for transcription accuracy.

Throughout my interview with Sophia, I was struck by her deeply compassionate approach toward therapy and life. Many themes emerged from our interview, including that of Sophia accepting her deafness alongside her growth as a psychotherapist; developing effective self-disclosure processes; and using patient reactions about her disability to further the therapy. The theme I found most interesting was how Sophia’s deafness – that is, both her and her patient’s experience of it – created space in the here-and-now for a real meeting to occur. In other words, the act of asking someone to repeat and of repetition itself required a relational space in which both parties participated in the making of speech, of psychotherapeutic contact, of shared understanding.

Interestingly, when her patients did slow down and spoke clearly, Sophia actually felt less attached to catching every word because the relational space between the two had allowed for something new to emerge. She explained:

For patients who genuinely have a conversation with me, where I’m welcome to comment any way, they create more process, they create more spaces. And then I feel it’s much less… I feel like I do say what I have to say. And I also feel like I can come back to something, if I think of something.
Moreover, that Sophia was able to relax about not always understanding her patients also contributed to the sense of expansiveness in the room. In talking about how her patients must feel, she said: “Oh, my goodness, they have to say it again. That would be – that I totally understand….that evokes my sympathy and my desire to help them do it in as gentle way as possible.”

Anna

“The more open I am with my hearing loss, the less people underestimate me…and therefore they respect me.”

Anna lived out west so we did the interview by Skype. Due to technical and connection difficulties, we also used text-based communication. Anna identified as audiologically deaf though she was very active in the culturally Deaf world. At the time of interview, Anna, who had a doctorate in clinical psychology, worked part-time at a university counseling center and part-time in private practice. She had been practicing for 30 years.

Common themes that emerged in our interview include the importance of time and experience on developing effective self-disclosure methods; the positive impact of disability on the therapy process; and the importance of not internalizing negative reactions from clients. Unique to this interview, however, was the way that Anna used her disability as a metaphor in her work with clients. She provided the following example:

I used to strain to hear a client, a quiet client, thinking that it was only my problem hearing them and then realized that others also have a hard time with their quietness. So I use my heightened awareness to underscore the communication difficulty […] ‘you know, I’m having a hard time hearing you and I’m wondering if other people in your life also have a hard time hearing you…”

Much of Anna’s therapeutic identity seemed connected to being able to use her disability in
the therapeutic process. Since practicing psychotherapy she had learned that clients felt less anxious when she educated them about deafness. “In fact, what I found is that when I don’t deal with my hearing loss it presents a lot more problems.” It was important to Anna that her clients and their families see that disability is not all-defining – that the glass was “half full rather than half empty.” Over time, she found that being open about her disability and using it in therapeutically beneficial ways “rewarded her over time” and that clients were “appreciative of that skill.”

**Bella**

“My colleagues were not at all as understanding as my clients.”

Bella, a licensed mental health professional, identified as Jewish and as a person with “sight-based problems and a degenerative disc disease.” At the time of the interview, Bella had been practicing for over 20 years and was currently working in private practice as an individual, family, and couples therapist. During the interview, Bella revealed that she also had a mild hearing impairment. We conducted the interview via Skype although due to technical difficulties as well as Bella’s need to see the screen we often relied on text-based communication. Throughout the interview, she was kind, thoughtful, and took care to make sure I could understand her. With long gray hair and large glasses, Bella looked like a classic psychoanalyst. She seemed comfortable talking about herself.

Our interview focused on the unfair treatment and discrimination Bella had received while in graduate school and beyond, including in her current agency. She talked at length about how she felt clients are more accepting than colleagues and experienced them less likely to make discriminatory remarks. With teenagers especially, Bella felt that conversations about her disability “[taught] them [about] compassion.” Bella frequently used story telling
and psycho-education in her work with clients, especially with respect to living with a visual impairment.

Interestingly, Bella did not self-disclose her hearing loss in the initial screening form but midway through our interview. Our conversation around this topic seemed to suggest that it was not a big deal for Bella, though I also wondered, given the continuous discrimination she experienced at work, if she did not want to identify as having multiple disabilities. Or perhaps she simply did not see her hearing-impairment as a disability in light of having a significant visual impairment. She stated: “I don't know if I ever disclosed [hearing impairment] to the clients. I say that I just didn’t hear you. They probably think that they [mumbled] or something like that.”

**Brenda**

“I became a therapist to understand myself…I never had a therapist who understood the deaf and hard-of-hearing.”

At the time of interview, Brenda worked for a mental health agency on the west coast. A graduate of an MSW program, Brenda had been practicing as a licensed clinical social worker for 38 years. She identified as culturally Deaf and wore cochlear implants. Most of our interview, which occurred via Purple Communications (a program similar to Skype), utilized ASL and text-based communication. Brenda stated that she worked with deaf children and adolescents as well as hearing parents of deaf children.

Of all my participants, Brenda seemed least involved with the hearing community; in fact, most of her work was with families of d/Deaf children. For this reason, our interview focused mostly on Brenda’s development as a therapist in the deaf community. She had received a scholarship to attend a social work program that wanted to recruit culturally deaf students; it was in that program that she gained the self-confidence to pursue her passion in
therapy. She stated: “I think sharing my experiences with other therapists like me helped […] to share some of our feelings and concerns and realize we share the same fears or thoughts.”

Brenda struck me as very confident in her Deaf identity. She described how she used the therapeutic relationship to explore client issues, especially client responses to her disability. In this interview I was also drawn to Brenda’s experiences of being a therapist with a cochlear implant after having worn hearing aids for many years, as illustrated in the following excerpt:

I have had a time when I unconsciously would take my hearing aids off after a stressful session but that was a long time ago. But now I have cochlear implant it helps a great deal. So I am not so tired or stressed out.

By becoming more “hearing” through the use of cochlear implants, Brenda was better able to participate in self-care and to navigate the daily challenges of practicing as a therapist. As my interviews demonstrate, not all participants had this choice or even wanted to make this choice, an interesting contrast that speaks to the personal choice of fitting into an ableist world or choosing to chart a different path.

Melissa

“As time has passed and my experiences have grown my disability has become far less of an issue than it was in the beginning”

At the time of the interview, Melissa, who identified as blind since early childhood, worked at a UCC providing individual psychotherapy to college students since 2004. Melissa lived overseas so we conducted our interview via email. While she credited her training, supervision, and own therapy as influences on her success, a recent venture into Gestalt therapy had been the biggest influence on her therapeutic approach.

Themes that emerged from our interview, which occurred over two e-mail
conversations, include the importance of time and experience on mitigating anxieties around disability; the growth of her identity as a Gestalt-oriented therapist; lack of accessibility for documentation, groups, and family therapy; processes of self-disclosure; and the methods by which she utilized her disability in the therapy space (e.g., to psychoeducate, to empathize, and to explore issues of transference and countertransference).

As I re-read Melissa’s interview, and thought about her experience with clients and in the workplace, I wondered about connections between Gestalt and feminist therapies. That Melissa frequently used psycho-education with her clients suggested that she may also be utilizing a feminist approach, wherein the focus is not just on the self but also a recognition that change needs to occur on a social level, a recognition that disability is a form of embodiment rather than something that denaturalizes. Together, in their conversations about disability, I imagined that Melissa and her patients actively co-constructed a relational world in which they both felt validated, heard, and supported – and perhaps also inspired to enact social change.

What stood out to me from Melissa’s interview was how strongly she felt supported by her colleagues (a theme not endorsed by many other participants), and I wondered if the support had to do with the fact that her country largely views disability as a social construction rather than a medical issue.

Jake

“Some patients have appreciated my blindness, saying that they feel less judged by their appearance […] this comes especially from patients with body image concerns.”

Jake, a licensed clinical social worker for over 13 years, worked in a large hospital in the southeast at time of the interview. He identified as blind and saw patients for psychotherapy for individual, group, and family therapy. He also provided supervision to
masters level clinicians.

Central themes that emerged from Jake’s interview included that of modeling for clients how to live with a disability; experiencing clients as less judgmental than colleagues; and being told that clients experienced him as more empathic than sighted therapists, as exemplified in the following example:

[One patient’s response was that I didn’t] judge her or try to change her or tell her that all the things she is doing are wrong. She felt that I got her because rather than focus on her questionable behaviors I was trying to see why she was making those choices and what was the original root of her motives.

In his emails, Jake often dropped hints about difficult experiences with supervisees and within his own life but often wouldn’t expand, saying that he didn’t “feel comfortable” describing it in email. When describing an interaction he had with a supervisee who was also blind, Jake said:

I feel that my uncomfortable[ness] with her is with her neediness. Apparently I have some of the same issues. I recall a youth telling me of being sexually abused and thinking how glad that it had not been me, only later to recall that it had happened to me in a similar fashion. I think that her blindness issues may be some of my own issues that I would rather not address.

His reluctance to open up suggested that the nature of our interview felt unsafe to Jake. This is likely the result of having not developed a full alliance; I wonder if we had conducted the interview face-to-face and developed more of a rapport, whether Jake would have shared more personal reflections.
Ellen

“I…feel my hearing loss has obviously shaped me.”

I interviewed Ellen over Google Chat; we initially were going to interview via Skype but Ellen stated that the connection at her house was not strong enough for a video interview. Ellen identified as audiologically deaf. She obtained a PhD in clinical psychology and had been practicing for 12 years. At the time of interview, Ellen worked for a non-profit organization and provided individual and family psychotherapy to children and families on a part-time basis.

Themes that emerged from Ellen’s interview included balancing work with family demands and using her disability as an educational tool in her work with children. By and large, Ellen didn’t experience her hearing loss as interfering with her work but she did feel it shaped her awareness of otherness and oppression. Although our interview was brief, I appreciated having Ellen’s insights given her focus on working with children. She frequently used her hearing loss as a way to model for her younger clients other ways of experiencing the world, and reported that the children often responded with an open curiosity.

Donna

“In the hearing community, I tend to only disclose when relevant.”

Donna responded to my call for participants early in the summer of 2014. When I responded to her initial email expressing interest, she wrote back and stated she did not have time at the moment but that she would be available in the fall. When we connected again, Donna said she was busy dealing with “discrimination issues” related to her deafness at a large government organization where she was a postdoc. She planned to resign.

Her responses to my email were brief and she didn’t respond to follow up questions; regardless, I have chosen to include her interview to demonstrate the difficulties deaf
providers face in the clinical field. Additionally, I felt personally invested in the outcome for Donna, which I explore in the reflexivity section. Donna identified as “hard-of-hearing” and saw both hearing and deaf patients for individual therapy and groups. Donna had received her PhD in clinical psychology the year before and had been seeing clients for seven years.

In her interview, Donna seemed bitter about her experiences, as seen in the following example: “If I thought suing would make a difference, I might consider it but as far as I’m concerned, this [organization] doesn’t care and I’m not going to waste my time.” She described how the agency denied her the experience of leading groups because they were worried about the impact of her hearing loss on the well-being of the patients. She also described how a supervisor felt she had misunderstood someone because of her hearing loss rather than external factors. When she attempted to describe her concerns, she was labeled as “defensive.” “As a result,” Donna stated, “I am losing my job and lost confidence in my skills.”

4.3 Navigating Challenges as a Therapist with a Disability

When asked about challenges, most participants cited a variety of topics outside the therapy space. Lack of accommodations within the workplace and the experience of ongoing microaggressions, such as negative comments about impairment from nondisabled supervisors and colleagues, were most often cited among participants.

**Negotiating accommodation needs.** Participants described lack of accommodations as an ongoing challenge despite the implementation of the Americans with
Disabilities Act (ADA) in 1990. Blind participants cited difficulty using Electronic Medical Records (EMR) for client documentation, a system that is not accessible with adaptive technology such as a screen reader. Limited access to EMR also impacts patient care. Jake, a blind social worker employed at a hospital, described how the lack of accessibility made it difficult for him to “[access] the notes of case managers and psychiatrists,” which in turn impacted the care he provided to patients (MU1.2). During his years on an APA committee, Alex, a blind psychologist, asked for assessment materials to be translated into Braille. The committee declined his request because they feared the materials would land in the wrong hands. Deaf participants described difficulty gaining access to interpreters, CART reporters, and transcripts of therapy sessions. In many cases, they only received partial accommodations due to limited funds.

Grace, a deaf PhD student in clinical psychology, experienced the lack of accommodations as an ongoing struggle. This topic was the central focus of our Skype interview. She wrote:

We are required to record client sessions and then analyze them in supervision or in practicum class […] I was not able to not only not hear my own sessions but also the

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6 This bill, which tried to ensure that the rights of disabled people would be protected, failed to include all individuals with physical or mental impairment, especially those with invisible disabilities. Since the 90s this bill has expanded to include many of these forgotten (invisible) populations but is still not without thorns. For example, while employers are mandated to provide “reasonable accommodations” to employees with disabilities, often what is considered “reasonable” is determined by the employer (and agency’s budget) and may not effectively meet the individual’s needs (Kemp, Chen, and Erikson, 2003).
sessions of my cohort mates or supervisees [...] so I was not able to give feedback.

(MU1.5)

Grace also described struggles within the therapy space, such as needing cameras positioned at face-level rather than up high so she could lipread sessions, and problems with movement sensors within the clinic that set off her hearing aids. She was reprimanded when she asked for the sensors to be deactivated, as illustrated in the following excerpt:

It finally came to the permission of the Dean of the school to turn all these sensors off. These are his responses when the IT director bought it up to him: “Who the hell does she think she is? Those sensors cost us money,” “Can’t we buy her new hearing aids?” “Can’t we keep her in the basement in the clinic?” and “What do we need to do to keep her quiet?” (MU5.14)

Because she was in such distress, Grace spent supervision hours talking about accommodations needs instead of clinical concerns. Rather than being supportive, supervisors repeatedly challenged her accommodation requests and failed to understand that despite being accomplished (e.g., obtaining a masters and entry into a PhD program), Grace still needed assistance to perform to the fullest extent without undue stress.

Reflecting on this theme, the challenge of accommodations becomes part of a larger systemic issue in which it is often able-bodied superiors who decided how “disabled” a person is and what they imagine that person needs based on perceived success rather than inquiring or learning about the disabled person’s actual lived experience. Reflecting briefly on my own experiences, I have been told in the past that I did not “need” accommodations because I got “good grades.” But the two were not synchronous – I got good grades because I spent hours re-reading the material and asking classmates for notes to make up for not having the information easily accessible. This time consuming activity actually further
disabled me in that I was often left exhausted and frustrated. In my example and those of my participants, we can see how traditional markers of success or “doing well enough” are frequently determined by normative/ableist standards that are often reductive rather than complex, and do not acknowledge that many accommodation requests serve a need that may not be immediately visible to others.

**Experiencing microaggressions.** One of the biggest challenges cited by participants was navigating the assumptions, remarks, and biases of colleagues and superiors. Microaggressions, often unconsciously communicated, refer to verbal, nonverbal, and environmental slights aimed to communicate hostile, derogatory, or negative messages, and targeted at persons based upon their membership in marginalized communities. The theme of being perceived as abnormal or incompetent emerged especially for participants who identified as blind.

Octavia, a psychologist working in a hospital setting, described how her colleagues expressed anxiety about her blindness:

I’m […] comfortable in the chaos [of working with psychotic patients in the hospital] and can tolerate it very well […] where everyone else is worried. “She’s blind, she won’t see.” […] And so there’s a hypervigilance about protecting me with peers and colleagues. They feel they’re going to have to run interference far more often than actually would be necessary. (MU 5.1)

Reading this passage one might wonder, “Where’s the microaggression here?” I interpreted Octavia’s use of the phrases “hypervigilance” and “run interference” to suggest that this experience marginalized her, even if it was not visibly apparent and her superiors meant well. In expressing their anxiety, especially in a way that does not invite Octavia to share her own experiences or clinical expertise, her colleagues put Octavia in the position of
having to do “diversity work,” to quote Sara Ahmed (2015); that is, to set aside her own needs and feelings to assure others of her competence and ability to do the job. This example brings up the question, “who gets to determine what constitutes as a microaggression?” Sometimes it is the person with the disability but often times such experiences are so frequent that they go unnamed because the person with the disability does not have the energy, time, or even interest to correct every slight. This is where education about microaggressions becomes useful; allies can also point out instances of microaggressions they see happening around them, as I do in attempting to problematize Octavia’s experience.

A more obvious example of a microaggression occurred when Octavia applied for an externship. She contacted the chair to let her know that she needed to reschedule because the car service for the visually-impaired was not available on that day. After hearing about Octavia’s disability, the director replied by saying she had never worked with someone who “wasn’t whole” and that she did not realize blind people held jobs at the level of a PhD (MU 5.1). This woman’s insensitive response suggested that she had not received adequate training, if any, in disability issues, and that she had not checked her own biases about disability or even recognized her own privilege. More importantly, this woman is probably not even aware that her comment demeans Octavia or that such training is needed. That Octavia chose not to say something in response further highlights the double power dynamic between them: the disabled student and the able-bodied superior.

A psychologist now employed at a university counseling center, Nadine also provided an example from a professor in graduate school who implicitly implied she was not whole. She recalled him saying: “Nadine, I expected you to be able to do 95 to 99% – well 90 to 95 percent of what your sighted classmates can do. You will never be able to be 100 percent in
comparison to them because you can't really see everything” (N6.2). While the microaggression is explicit in this example, we can also wonder about the role of gender in this comment: would he have said something so direct to a male student with a visual disability?

Similar experiences were echoed among deaf participants. When asking for accommodations, Grace said her advisor told her that they were “not used to disabled students at the PhD level”; they also seemed to believe that rather than working hard, Grace relied on her “accommodations to get [her] through the work” (MU5.6). A year later, when the program accepted a blind student, and Grace asked them why the blind student’s request for accommodations was met faster, Grace was told that she was “too functional” and that the “blind girl” clearly needed help (MU 5.6). This comment speaks to the larger stereotypes that nondisabled people often make about the blind and deaf – that to be blind is the worse of the two disabilities (Siller & Chapman, 1967) – and further reduces the complexities of the lived experience of Grace and the incoming student. Who gets to determine that the blind student “clearly needed help”? These three examples speak to the gross, ignorant assumptions often held by able-bodied psychologists, including those who have received training in multicultural issues; the problem is that such courses often do not include discussion on the tensions inherent when discussing disability.

For some participants there existed a tension between wanting to ask for accommodations and wanting to problem solve on their own, even if it meant needing to pass as able-bodied; that is, allow oneself to be perceived as having access to all the material. Nadine’s example comes from internship year:

I wasn’t expecting them to make accommodations because I wanted to come in with the problem solved already. Do you know what I’m saying? […] But on the other
hand, I want access to my materials. (Laughing.) And that's a little annoying. (N4).

A deaf postdoctoral resident, Donna did not want to utilize an “interpreter or CART services if they [were] not 100% needed” as she felt it had a negative impact on the therapeutic alliance. But she also “[got] tired” of people not asking whether she needed accommodations and assuming she is “hearing” (D2.2).

These two examples highlight the complicated feelings people with disabilities experience when speaking up about accommodations or microaggressions. Yet, as Donna’s experience demonstrates, those with disabilities are not immune to making problematic assumptions around those who may wish to help or to understand. Reading Donna’s interview, I had the impression that people did want to help but Donna’s own complicated relationship to her disability might have gotten in the way of her having open conversations with colleagues about asking for accommodations. For example, how does using accommodations negatively impact Donna’s experience of the therapeutic alliance? I wish she had spoken more about her experiences in our interview, something I further ponder in the reflexivity chapter. As discussed next, the experience of microaggressions is further complicated by the power dynamics that exist between my participants and their nondisabled supervisors or colleagues.

**Negotiating power dynamics.** As participants spoke about their experiences, the implicit theme of power dynamics repeatedly appeared in our conversations, especially with respect to microaggressions. The following example comes from my interview with Octavia:

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7 For the purposes of this dissertation, I mostly reflect on power dynamics as they occur with respect to disability. This is not to erase the importance of how race, gender, sexuality, age, and other minority status also influence power issues within the workplace.
Everyone wants to be the good student. They’ll say, when I’m leaving the room, “Dr. ---, your cane is over there.” [...] So there is that kind of change of dynamic [...] I can come in with an equal peer, or a trainee, an extern who’s going to co-facilitate, and the community will focus on [me], making sure that I am set up in a way. “No, no, Dr. --- always sits right there.” So they’ll protect my territory or whatever [...] and sometimes I’m concerned about that dynamic. (O11.1)

This example illustrates the role power played in the different reactions that students and colleagues had about Octavia’s disability. Students responded by helping too much (which may reflect their understanding of the hierarchy between them and Octavia with respect to training) whereas colleagues were more likely to doubt her skills (which may reflect beliefs about disability). In our conversation about this experience, Octavia questioned her own role in negotiating the power dynamic by turning the attention away from herself. She stated:

I find that what it causes me to do is, maybe hyper-elevate a student. Right? I keep emphasizing, this is my colleague, this is my colleague, when in all actuality this is a trainee who’s under my supervision. (MU7.6)

In shifting the attention to her trainee to show them as “competent” to patients, she was able to escape “preferential attention” (O11.3), something that I imagine increases her own anxiety about how she is perceived. Octavia wondered if this dynamic existed because of her blindness (as she observed a more “equal playing field” among other students and psychologists) or if it was because she holds the title of doctor (O11.4). From my own perspective, I’m not so sure the two identities can be so easily teased apart – it is likely that her students unconsciously responded to the unexpected juxtaposition of disability and senior professional status.

In our interview Alex recalled being denied a TA job; although he couldn’t prove it
was due to his disability, there also didn’t seem to be any good reason why he didn’t get the job, especially when others in his cohort did. He reported that this experience “affected [him] as a therapist…[feeling that he did not get] certain opportunities that other people might have had if they didn’t have a disability” (MU5.10). When asked why he was denied a position, his committee’s vague, non-committal answer suggested that feelings about disability, even if not consciously articulated, were at play.

Donna, a postdoctoral resident in a large government organization, chose to leave her position because of microaggressions and lack of understanding by her colleagues. She stated that her supervisor has “taken experiences away from [her]” because of her deafness, and as a result she is “losing confidence in [her] skills” (D3.1). When she expressed concerns to her supervisor, she was called “defensive” and since then has not spoken up (D4.2). This example, along with Grace’s in the previous section, demonstrates how graduate students with disabilities may not feel comfortable speaking up due a variety of reasons, such as fear of not getting a letter of recommendation, lowering of grades, or being asked to leave the program (Olkin 2010).

These examples demonstrate the shifting of power dynamics between my participants and their supervisors, colleagues, and trainees, with attention to who holds the power and when. As such, when supervisors wield power over a supervisee because of concerns about disability, this also constitutes a microaggression. Over time, the accumulating experience of microaggressions may lead to feelings of isolation, as discussed next.

**Standing apart: experiences of isolation and loneliness.** Throughout interviews, the theme of isolation and loneliness emerged repeatedly. While most participants knew of one or two other deaf or blind therapists, there did not seem to be a strong connection to a
community of other disabled therapists. When asked about whether she identified with a community of other blind therapists, Nadine replied: “There really aren’t that many. It’s very sad. There are not that many” (MU3.1). Yet, that Nadine doesn’t actively seek out a community of other blind scholars makes me wonder what is sad about it for her or if she feels she should have such community because that is what others might expect. Speaking from my own experience, I know that people are often surprised when I say that most of my friends live in the hearing world.

Octavia laughed when asked the same question. Though not explicitly stated, that she trailed off at various points suggested possible feelings of uncertainty around not having a community, and perhaps a longing for one:

Sorta – kinda [have a community]. Sorta. Um. (Laughs.) I belong to several list serves for blind and visually impaired mental health workers. The greater number of those individuals […] come from social work. […] And so their experience in some ways is very similar, but in other ways very different. I don’t know any one of them personally or intimately. And as far as a community of individuals who look like me, if you will, I don’t have that. (MU3.2)

Participants who identified as audiologically deaf seemed more certain in their belief that there were not many therapists like them. This certainty may be attributed, in part, to the division between Deaf Culture and the audiologically deaf. Those who identify as being a member of Deaf Culture, even in a large city, are more likely to know each other due to having their own language and small membership; those who identify as audiologically deaf or hard-of-hearing, and who exist mostly in the hearing world or a combination of the deaf and hearing worlds, may not interact as much or even know of one another. “There are not that many hearing-impaired therapists out there,” Brenda stated with much gusto, and added
that she wished she had a deaf therapist growing up (MU 3.4). Jaime agreed: “There are only a few deaf therapists…especially those with acquired deafness” (MU3.5).

For Jaime, finding her place among the audiologically and culturally Deaf worlds while still identifying as hearing-centric helped her to combat isolation and loneliness. Around the age of 40, her hearing decreased significantly to the point where she felt it was negatively impacting her practice. She coped with these challenges, in part, by getting cochlear implants. She stated: “With my hearing clients it’s like I come home and I feel more confident. I feel like more me. You know? I’ve been hearing, hard-of-hearing, deaf, then deaf to hard-of-hearing to [having more] hearing now” (J6.2). Jaime’s experience of loneliness seems connected to her narrative of identities. On the one hand, she wants to not feel anxious about being deaf with hearing clients, but she also wants acceptance by her d/Deaf participants. She wants to feel comfortable straddling both worlds but when the d/Deaf and hearing worlds don’t always seamlessly interact, the straddling becomes complicated, if not painful.

**Speechreading fatigue.** Clients with accents or who move their mouths in ways not easy to decipher posed challenges for my d/Deaf participants who primarily rely on lipreading (or speechreading). Brenda described it as “draining” and remarked that she used to take her hearing aids off after the end of a session (BR1.2). Jaime stated that she had difficulty understanding foreign accents, which she frequently encountered in her second job as a consultant. She jokingly referred to this challenge as “lip-guessing,” sharing with me that “only 30 percent of the English language is visible on the lips” (MU6.3). Sophia experienced that it was not just accents that pose difficulties but the client’s physical comportment of being-in-the-world:

One of [the challenges] is the structural stuff where there are clients I still, no matter
how hard I try, I just cannot hear. They talk too softly, or they’re depressed and their voices are way down and they’re not showing very much. (MU6.4)

She experienced the challenge of having to lipread a fast-talking client as one that left “less opportunity for responsiveness” (MU6.4).

On the whole, regardless of accents, lipreading as an method of understanding was described as exhausting, as Jaime eloquently described: “You’re reading constantly, your eyes are being used 24/7 practically. And other times you sit there and you just close your eyes for a minute and how they burn and you’re thinking ‘I'm just so tired’” (MU6.3). Grace described this exhaustion as universal to all disabilities:

There is this ego depletion or exhaustion, if you will, that I think all disabled individuals experience in trying to function in an [able-bodied] world – for me I feel like sometimes I am too tired to hear and do not have the strength or energy to try to hear anymore that day. (MU6.5)

These remarks, as supported by recent research on listening effort and fatigue (Bricker, 2015), make it clear that lipreading is not always experienced as “cool,” as it is frequently stereotyped in the media. It is a challenge that requires the physical labor of always keeping one’s eyes trained on the person speaking, such as when doing therapy. Thus, it seems that for deaf therapists who lipread appropriate self-care and breaks between sessions is necessary for doing optimal work – something I have also recently discovered on internship while having 6-7 individual sessions most days of the week. Self care was also cited as a way to cope with the multiple challenges of being disabled in an ableist world.

**Responses to challenges: Effective coping mechanisms.** As they discussed the aforementioned challenges, many participants also shared, unprompted, creative responses and solutions. Positive thinking, realistic expectations, and remembering reasons for entering
the field were frequently cited as coping mechanisms (see MU8.1). For Octavia, “realizing the greater purpose and helping someone with a mental health issue was incredibly rewarding,” as before her brain injury she had not tended to “value what was actually happening in those processes,” and to be “forced into it by virtue of career […] opened up [her] eyes” (MU 12.5).

As mentioned earlier, self care was cited as another coping response to challenges. Often self care is associated with things like meditation, eating well, and exercise, but my participant interviews demonstrate how self care is something that happens in the everyday, minute-to-minute interactions with others. A frequent example of self care was that of not internalizing patient remarks about disability, as illustrated in this excerpt from my interview with Sophia: “If someone tells me I can’t help them, I don’t personalize […] so much about a disability is internalized and really it takes a while to separate from that and to recognize […] the true limitations” (S1.3). Ellen described working with “a paranoid schizophrenic with delusions and very concrete thinking” who “latched” onto her hearing loss as a reason to not work with her (MU8.11). Rather than taking this client’s comment personally, Ellen saw it as symptomatic of the client’s ongoing struggles. This example demonstrates how training in psychotherapy might actually serve to provide a positive buffer against the negative comments and rejections that occur in the everyday world. We can imagine that such comments are taken less personally outside of the therapy space given the training my participants have in understanding client projections, fears, and transference.

For Anna, self care involved educating hearing clients and colleagues about the benefits to sign language. She wrote: “I used to hide my sign language and what I find [when] I sign with my hearing clients […] is that they really like it […] the reason they like it is because it helps them understand how feelings are expressed” (A3.3). Anna’s experience
made me wonder how many other deaf therapists who use sign bring it into their work with hearing clients as a way of demonstrating the relationship between physical movement and emotional expression.

Over many years of practicing, Jaime learned not to stress if she did not hear something, as what’s “intense” and “painful…will come up again” in the therapy (MU8.3). In these moments when they miss out but do not inform patients, Jaime and my other participants ostensibly pass as hearing; they make the conscious choice to let go some of the material. While this might seem ethically harmful to those who do not face such a challenge, passing is not as simplistic as it may appear: it is a complicated choice that can actually serve as a form of self care in a world where getting all the information all the time is impossible for everyone, disabled or not.

Self care was also equated with recognizing one’s limitations and setting boundaries with clients. Octavia chose not to work with couples because “catering to dual needs” with her disability presented too big of a challenge (MU2.4). Sophia didn’t hesitate to refer out suicidal clients whom she could not lipread, as she did not want to take the risk of endangering the patient or herself. When asked about her preferred therapy modality, Melissa said that she liked doing individual work. She wrote: “I am not keen on doing group work because I think my blindness [is an] impediment in [that] environment” (MU2.3). She felt it was important to “have visual information on all group members [in order to] keep track of what’s going on in the group” (M2.1).

Rather than feeling disappointed or frustrated at what could be perceived as a loss of opportunity, participants seemed comfortable with their choice to work with certain clients or within certain therapy modalities. In fact, the ease with which participants spoke about this topic may well be linked to length of practice. That is, new therapists, especially those
who may already feel criticized by supervisors, such as Grace, may not have the privilege or capability to refer out clients they cannot lipread; additionally, therapists starting a private practice may feel pressure to keep a client for financial reasons rather than refer out.

In conclusion, while some challenges were due to participants’ disabilities themselves, the variety of challenges participants faced were frequently due to lack of accommodations, microaggressions, and ableist views and assumptions about disability, all of which contributed to feelings of isolation and loneliness. These themes suggest that awareness of disability issues on a larger scale is not yet happening within most graduate training programs, continuing education trainings, or at psychology conferences, as illustrated by the insensitive woman at Octavia’s interview site. On the phone to my participant, after denying her an externship opportunity, she stated: “I’ve seen them [blind therapists] present at conferences; I didn’t know they really practiced” (O10.5).

In our interview, Sophia talked about how ADA laws have actually made it harder for her colleagues to know how to start conversations about disability without fearing repercussions. She described:

[Back then] there was no thought about accommodations […] they could ask you about the disability. With the ADA they can’t exactly. So that’s what I mean for better or for worse […] It became something that has to be more secretive, less out there and obvious. (S2.1)

Rather than being something that represents universal accessibility, ADA’s straightforward language about what is and is not acceptable may actually shut down conversations about disability that need to happen in the psychology field: conversations that may make those with hearing and sight feel momentarily uncomfortable as they recognize their able-bodied privilege, conversations that require vulnerability and openness. Only when such
conversations occur at the level of emotion and deep personal reflection will the prevailing discourse about disability shift to a more positive, vulnerable, and affirming direction.

It is my hope that this section of my results chapter will educate the larger psychology community about the challenges deaf and blind therapists face and how such challenges are often unconsciously perpetuated in the workplace and in training programs by hearing and sighted colleagues. Participant stories also highlight the need for disability issues to be incorporated into multicultural diversity classes taught in MSW, PhD, and PsyD programs. Ideally a professional who can personally speak to his or her lived experiences with respect to disability would lead such conversations. Although my participants developed effective methods for addressing such issues (including self care), they should not be solely responsible for educating others about ableist privilege and disability issues. Rather, from an ethical and justice standpoint, this work should fall on everyone in the larger psychology community. In a wistful moment in our discussion, Octavia shared that she often “imagines what it would be like if everyone would sit in the room with their patients with their eyes closed.” She wonders “how much more connected they might be…” (O15).

4.4 Disability as it Shapes the Therapist’s Development

Aspiring therapists are often asked in graduate school interviews why they want to go into the field. In their book, *On Becoming a Psychotherapist*, Klein, Bernard & Schermer (2011) discussed a number of relevant factors, including early life experiences, personal background, critical developmental events, traumas, mentoring relationships, supervision, and experiences within personal therapy. A factor not explicitly mentioned, and perhaps a key oversight, is experience of cultural or physical otherness, such as disability, and its impact on empathy and relating to others.
A few of my participants went into psychotherapy because they wished for a deaf or blind therapist as an adolescent and wanted to give back to the community, or because it seemed like a natural transition point after a life-changing event. Others stated that they wanted to teach clients how to self-advocate and stand up for themselves. The following excerpt comes from my interview with Alex:

I think a lot of the factors [as to why I went into psychotherapy] had to do with the reality of my disability […] all through high school, even my young adulthood […] I didn’t want to feel different. […] I didn’t want my disability to be such a prevalent part of my identity in defining me in what I could and couldn’t do, although it did. […] I think [I have an] inherent appreciation for people [with] different life experiences and maybe experiencing some level of emotional pain in their life. (MU 10.1)

Like with Octavia, Alex’s acceptance of his disability seemed to make him more curious about other people’s struggles and experiences of oppression, which in turn impacted how he took up the therapeutic alliance and transference, topics discussed later in this chapter.

The process of looking inward also put participants in touch with their own anxiety and worries about rejection. Often this anxiety was exacerbated by the participant’s own relationship to their disability – if they felt less comfortable, patients were likely to pick up on that as well. Over time, Jake realized that having self confidence “offer[ed] [clients] a security of [his] clinical abilities” (MU11.5).

For Melissa, time and experience have helped her to feel more comfortable with being blind. In an email to me, she wrote:

As time has passed […] my disability has become far less of an issue than it was in the beginning […] It’s like in the past I may have attributed my being blind to a
specific piece of work that a client did or a comment they made [...] I have become far more comfortable with my blindness as a result of doing my own therapy and through settling into my role as a psychotherapist. (MU11.4)

Anna also described being more open with patients about her hearing loss as she journeyed through her own process of self-acceptance: “The oddness of how to handle my hearing loss with hearing clients have definitely gotten better [...] going from wanting to ignore it [...] to now [being] very open about my hearing loss” (MU11.1).

Alongside experiences of disability, a few of my participants also described early losses in life that contributed to their decision to seek out a career in psychotherapy. The multiple effects of loss coupled with the everyday micro-trauma of living in an ableist world suggest that process of becoming a therapist served as a kind of corrective function, perhaps one that filled an internal void.

**Perceived support and relationship to self confidence.** My interview questions also include a component about participants’ experiences of graduate programs and training. Having moved through my own program with relatively few hiccups, I wondered if others had similar experiences. Throughout coding, I became curious about the relationship between therapists’ view of themselves (as competent clinicians) and the support they received in graduate school.

A few participants described mostly positive experiences; interestingly, these participants attended specialized programs (either geared toward attracting others with disabilities or within a specific theoretical orientation). Brenda attended a social work program that had a grant for deaf and hard-of-hearing students, thus increasing avenues of support, visibility, and accessibility. For Brenda, “it was worth being in a world where you can interact with everyone, such as the deaf, hard-of-hearing, late-deafened and hearing, [as]
it [helped] decrease the isolation” (MU9.8). Melissa also had largely positive experiences while working toward her certificate in Gestalt Therapy. Given that Gestalt theory often focuses on relationships and felt experiences, perhaps it is not surprising that she had a better experience than if she had been in a general mainstream program. Melissa wrote:

I felt that my trainers were very accepting of my having a disability and were willing to learn alongside me how I developed as a therapist. I really liked the way they honored my experience of knowing myself and my prior experience of living with a disability […] me being an expert on myself. (MU9.9)

The most common experience, however, was that of having mixed support at various points in the training program. Participants spoke about having support in one area (often determined by resources) while other needs went unaddressed. Although Alex had wonderful support during internship when he worked with a supervisor who was also blind, during his training years he felt discriminated against because of blindness. He stated:

It was shortly after the ADA came into existence. So I did get a lot of support in that way by having extra time and some resources. Scribe and a reader and things like that. I didn’t get a whole lot of help with textbooks or things like that. That was still a relatively new domain and I did feel discriminated against in terms of graduate assistantships. (AL2.5)

While Octavia had a negative experience during internship interviews, she ultimately felt that the support she received during internship year set her on a path to greater self confidence. She stated: “Being at [name elided] allowed me to feel dignified in my blindness. And that dignity allowed me to become competent in my practice, or to begin to develop competency and confidence” (MU9.4).

Having only negative experiences in graduate school was less common among
participants. Over Skype, Bella described a particularly negative experience:

In graduate school one of the professors thought it would be fun to pretend to be blind. He had the class close their eyes and walk around bumping into each other and into inanimate objects. So many were giggling, what a fine old time! I of course did not participate and when questioned why, I explained that being blind was not a game, was not fun and was not something to be taken lightly […] The class became silent and the professor was quite embarrassed […] I think I taught him more than he taught me that semester. (MU8.5, 9.10)

Bella’s example offers an interesting contrast to a remark made by Octavia in her interview: that she sometimes wished her colleagues would imagine what it is like to be visually-impaired by closing their eyes. As I coded Bella’s interview, I wondered if her path to becoming a clinician was more negative than for my other participants given that she was older and trained during a time when many were not aware of disability rights.

Interestingly, I noticed a trend between those participants who only talked about negative experiences in graduate school and a sense of generalized negativity infused through the interview. Those who spoke only about positive experiences in graduate school also had a generalized positive view throughout the interview. This relationship might be understood in light of graduate school being a formative time in one’s development and understanding of one’s self as a therapist. For example, Donna was a bit brusque in her interview and focused mostly on negative experiences. An excerpt from our interview is below:

Donna: Currently, the administration and my supervisors are the ones making rude comments. For example, my supervisor assumed I misunderstood someone because of my hearing loss […] I didn’t say anything. I had already been called “defensive” when trying to explain my point of view so I did not feel safe to share my thoughts
Initially I experienced Donna as being a bit brusque in her responses, but writing this now it seems like Donna was simply being straightforward in her responses; it’s possible she experienced my response to her statement as too empathic given that we did not know each other. I wonder if this comment was an underlying message to me that I could have done more to make her feel comfortable. At the same time, it is possible that she felt put off before even starting the interview, given the nature of my topic.

Finally, some participants experienced positive support during graduate training but discrimination during internship and the job market. In her interview Sophia alluded to the notion that academic institutions, on the whole, may be more aware of disability issues than non-academic workplaces given that most academic institutions have a disability support services office. Yet, this is not always the case, as Grace’s interview demonstrated, when individuals within the larger institution are not trained on disability issues.

**Relationship between theoretical orientation and views of disability.** While coding, I also looked for implicit themes across the various interviews. Results pointed to a possible relationship between theoretical orientation and participant views of disability. That is, the participant’s theoretical orientation seemed to shape how they perceived and talked about experiences of being blind or deaf. Conversely, experiences of being blind or deaf may have impacted the orientation by which the therapist practiced. For example, Alex chose his graduate program for its multicultural focus, as the training philosophy fit with his social justice oriented views and desire to understand how his otherness and that of his patients intersected.

Early in our interview, Nadine stated that she always had an “interest in trying to figure out how people worked” (N1). When asked about how her disability impacted that,
Nadine replied, “It does not...[when] working in a cognitive behavioral model, the student sets the goals” (N1.2). Although she had received training in psychodynamic approaches, she felt that her disability did not “interfere” with her clinical work (MU 23.5). She went on to describe how her experiences with oppression as well as problem-solving with regard to her disability had “shaped the way [she] works” (N1.3). For Grace, her disability has shaped her choice of theoretical orientation. She stated:

Dealing with multi-systemic oppression [has] influenced me to conceptualize in a systemic way and a feminist/multicultural way [...] Thus, coming from [a] disability view allowed me to see the client from their view as a minority, due to gender, low SES, or what their life is like due to trauma or divorce. [...] It made me willing and able to shift into their perspective and try to see it as they see it.” (G3.1).

In sum, these interviews demonstrate how the development of the therapist’s professional self intersects with self-acceptance of disability, support in graduate school, and access to a community of other marginalized populations. These interviews suggest that personal and professional growth is an ongoing process, one that is impacted by the experience of microaggressions and perceived support. In some ways, participant self-growth stemmed from enduring hardships around lack of accommodations and discriminatory remarks; in emerging with a few scars, so to speak, participants seemed more confident in their abilities to relate to others and to provide effective therapeutic care. With respect to the larger psychology community, these themes also highlight the importance of supervisors and department chairs receiving adequate education in disability and social justice issues, especially with respect to their own biases and privilege.
4.5 Impact of Disability on the Therapeutic Dyad

The above themes illustrate the lived experience of the therapist in the everyday world: at work, in graduate school, and in their interactions with colleagues. As we step inside the consulting room with the therapist and client, new and richer themes emerge at the intersection of disability and psychotherapy. The first of these addresses the start of therapy with a new client: how and when do blind or d/Deaf and hard-of-hearing therapists decide to disclose their disability to clients?

**Self-disclosure of disability and relationship to power dynamics.** As I developed my interview questions, I wanted to see if therapists’ preferences around self-disclosure had an impact on the alliance and client reactions. Most of my participants reported that they disclosed in the first session. It was interesting to note that while some participants disclosed while walking from the waiting room, others self-disclosed after preliminary introductions, and yet others self-disclosed at the end of the first session. Those who self-disclosed at the beginning of the session often did so in what appeared to be a rather straightforward manner. The following is an excerpt from Anna’s interview:

> I say something like: “Before we get started let me tell you a bit about myself. I'm hard of hearing. And what that means is I do hear you some and I lipread you. And there may be times I might not understand you and there might be times you don't understand me. And if at any time you have a question, please ask me. And if I don't understand you, I'm going to ask you to repeat it. And if you're not comfortable at the end of the session about working with me, no problem. I'm happy to refer you to one of our other therapists.” (MU23.2)

Octavia reported that she did not invite elaborate questions around her disability in a group setting because she believed it detracted from the group dynamic and turned the focus on
her. Individual psychotherapy was a different matter. She explained:

I come out with the cane, and then when we get back to the office [I make] the normal disclaimers. And then I will say, “One other thing that is important for you to know about your therapist is that I’m cortically blind. If there are any questions about what that means or how it might impact our relationship, I invite our exploration.” (O13.1)

Sophia preferred to self-disclose after the first session so the patient got to experience what it was like, rather than being told what it would be like. I include this lengthy excerpt to portray not only her process but also the amount of time and energy she has put into finding what worked for her:

I have learned not to tell them right away. Not to start out with it. It creates more anxiety than it stops [...] Most of those disclosures have gone over well because that’s why I wait. Because the client has already had an interaction with me and is realizing that I am getting things. [...] So they have a more realistic idea of, um, when I say that I don’t hear well. I let them know that I don’t hear…I hear by lip-reading. I see what they say. That the telephone, for that reason, doesn’t work for me. So that’s the kind of information I tell them. If I were to tell them in the beginning, it’s their image of what that’s going to mean. When I tell them later in the session they already know what that’s going to mean. (MU23.9)

Moreover, the process by which one self-discloses changes over time. Alex described how he went through different stages of self-disclosing depending on how he felt about his disability at the time:

I’ve gone through different stages where initially I thought I needed to talk about it. Then there was a period of time when I didn’t talk about it at the beginning of
Jaime and Donna discussed how their disclosure styles varied depending on whether they were working with hearing or deaf clients, especially with regard to cultural norms. Donna explained:

In the hearing community, I tend to only disclose when relevant. For example, when explaining why I am asking them to repeat or if they have hearing issues […] Hearing clients don’t tend to ask follow up questions but I would answer them if they did. With deaf clients I am open too because that is the culture. You share much more with deaf clients than hearing. (MU23.4)

Unlike most participants, Jaime consciously chose to minimize her hearing loss from the outset and does not self-disclose in advance. She described as follows:

When [they] get here and it becomes an issue, I will say flat out. I don’t hide it. I will flat out tell them if it’s an issue, okay? I don’t bring it up immediately. If it gets to be an issue, “Oh, by the way.” I will minimize it. (J7)

Jaime’s self-disclosure style was not just a professional choice but also a personal one; she elaborated on the personal side of this process in her member check response:

[My self disclosure process is a] psychological need in maintaining my own hearing identity [more] than it is any external acceptance or rejection by others. Childhood trauma was a major reason for my hearing loss/deafness – and this, in and of itself, is complex and complicated especially on [my] survivor’s sense of identity.

This excerpt illustrates the complexities between how disability is perceived by others versus the actual lived experience of disability; for Jaime, her relationship to deafness is compounded by the effects of multiple traumas. In fact, we can imagine that not having had
many of her needs met as a child with respect to deafness also constituted a trauma.

For Grace, self-disclosure included more than just her disability but also her ethnic background. She strongly believed that her difference added something to the therapy and wanted her patients to know this from the outset:

   I tell them in the first session – I am a [country elided] immigrant disabled female that moved into the cornfields of Indiana from New York City. I disclose all of it and assure clients that the fact that I am different from them is not going to be a hindrance but an asset to therapy. (G4.1)

As demonstrated above, self-disclosure styles vary from therapist to therapist and play a necessary part in the therapist’s own self-confidence about their work. Yet, as Octavia brought up, the choice to self-disclose is also about personal ethics:

   On [my listservs], a lot of other professionals are very concerned about the perception of being deviant in not having disclosed. Like being deceptive in some way. And how fair is it to […] show up […] blind. Well, I show up and I’m black. You know? You can’t hear it on the phone. So yeah, I show up and I’m blind.

   (O13.2)

   Whereas others might see Octavia’s choice not to self-disclose as an ethical breach, for this participant ethics are intertwined with her identity as a blind person; the two cannot be easily separated. Why should she have to disclose blindness when others, herself included, do not disclose blackness? This example highlights the intersectionalities of multiple oppressions, and how normative understanding of ethics becomes problematized when intersectionalities of multiple oppressions are at play, especially when such oppressions are not always “seen” by the able-bodied.
Patient responses to disclosure also influenced the co-created dynamic in the therapy space, including the power dynamic. The psychotherapy framework naturally creates an “inherent power differential” between therapist and client (Pope & Vasquez, 2007, p. 43). The client pays the therapist (or agency) for a service, the client puts their trust in the therapist, the client is dependent on the therapist, and the client is (most often) in the vulnerable position. In all therapy relationships, the power dynamic often shifts depending on the processes taking place. For example, when the patient pays the therapist, the power is skewed toward the therapist. When the patient chooses to terminate, the power is skewed in their favor. When the patient chooses not to reveal information that might be helpful for the therapist, power is also skewed. Melissa sometimes experienced the client’s power when, for example, they came to the session with another person without letting her know in advance and failed to introduce them (M6.6).

While the balance of power is not always this simplistic, it is important to note that slight power shifts continuously occur throughout the therapy session, even if unconscious to both parties. For example, Sophia recognized that, after disclosing her disability, her patients had power when they chose not to repeat, or when they said, “never mind” or “I forgot” (S7.3). By gently empathizing with their difficulty and getting her patients to talk more about their reactions, Sophia can reset the balance, so to speak, and neutralize the power dynamic. After these interactions happened, Sophia felt that the relationship had been strengthened because they “[knew she was trying]…and really paying attention” (S3.5).

Many participants reported that their clients seemed accepting and expressed a desire to understand. The following excerpt comes from my interview with Sophia:

Most of my patients say […] “That’s fine, that’s okay.” Let’s see. A rare response […] “that could be good for me, I should probably slow down anyway.” A…less
common response is, “Is there anything I should be doing differently?” “Should I talk louder?” They want to know what it means for them. (MU24.11)

Brenda has experienced many different reactions depending on the client and their issues. She wrote: “Some go right ahead and keep talking about their problems. Some became a little stunned. Some act like it isn’t a problem or they want to be sure that I can understand them” (MU24.6). Bella reported that many of her clients responded to her disability with a joke (which she saw as a sign of anxiety) or by trying to help. She stated: “I think that for some of the clients it was eye opening – they could feel for someone other than themselves. For others it perpetuated the caregiver role that they had in their families” (MU18.9).

In the examples provided by Sophia, Bella, and Brenda, we see instances of anxiety and also helping behaviors, emotional responses not so unlike those portrayed earlier in this chapter by colleagues or trainees. The difference, however, is that the therapy space, unlike the workplace or school setting, seems to allow for vulnerable conversations to take place.

Bella also shared that she used to take client rejections personally but had since learned to separate herself and to see the rejection as part of the client’s own issues:

I think that for some of the clients [my self-disclosure of blindness] was eye opening. They could feel for someone other than themselves […] One or more times the client got very aggressive about the sight disability. It made me uncomfortable. I had to get in my head that it was more their fear, or they were used to being bullies and this is a way that they could bully me and detract from their own issues. (BE2)

In summary, participants reported trying out different styles of disclosure at various points in their therapy career. Disclosure styles were interconnected with participants’ acceptance of disability, comfort with conversations about disability, and the type of therapy setup (e.g., group versus individual). The commonly held belief that disability evokes anxiety
in the observer (Watermeyer, 2012) is both supported and challenged by my findings. The key is what therapists do with the anxiety that others express, anxiety that often stems from social constructions of ableism, which is really about social constructions of living and dying. When conversations about disability take place within and outside the therapy space, power dynamics become necessarily problematized such that social and ableist norms become deconstructed.

**Talking about disability enhances therapeutic alliance.** By and large, participants felt that conversations about disability served to enhance the alliance or to neutralize the already existing hierarchy, whether from their perspective or that of the patient. Alex described:

I think there's times when people are going through hard times themselves and it may be something completely different than a physical disability issue, but [...] I think it can be therapeutically beneficial to them to know that I do understand what it means to be different. I do know and understand what it means to be discriminated against. I do understand [...] what it means to hurt [...] or feel alone. (MU17.4)

Much of the meaning Alex derived as a therapist came from his work with patients who had disabilities. He often reflected on and spoke from his own hardships to provide what he called a “therapeutically beneficial” experience for his clients. When describing his work with patients in a mental health hospital, he stated:

[It seems like they] didn't feel...different or inferior or something just because maybe they were lower SES or different ethnicity than I was. I think maybe they were able to connect with me and I with them at a different level [...] as a positive benefit of having the disability. (AL3.4)
For many of my participants who worked with clients who were in some way othered, having shared experiences of oppression positively impacted the therapeutic alliance. Octavia described:

Sometimes individuals connect with the fact that there’s a brain injury or that something happened to me in my life, so that life alteration provides hope. Clients will say – “You’ve gotten over – gotten through. So I can be hopeful because I see that it can be done.” (MU18.4)

Octavia believed that the experience of being blind, as experienced in the here-and-now, had therapeutic value in that it allowed her patients to feel “more willing to open up” because she could not see them; they felt “less exposed” (O12). She provided an example in her work with a transgender patient at a hospital:

She said, “I love sitting with you. I said, “Help me understand what it is that you love.” She said, “You can’t see me so you’re not judging me and I feel like I’m more of a woman in your presence than in anyone else’s.” (MU16.3)

A few of my blind participants stated that their patients felt more comfortable with the therapist not being able to visually perceive them like everyone else. Melissa commented that her clients with eating disorders often felt more comfortable and less “judged” and exposed because they were not being perceived in the same way a sighted therapist would see them (MU16.4). Jake had a similar experience:

Some patients have appreciated my blindness, saying that they feel less judged by their appearance. [This comes] especially from patients with body image concerns […] body dysmorphic disorders; [they voiced] their relief that I was unable to see them. (JK2)

Offering a slightly different take on her work with children, Ellen believed that her need for
repetition could spark curiosity and open space for conversation:

I think [my deafness] may actually enhance the alliance at times with some kids who have trust issues with adults; while there are moments of frustration when I miss something a child has said, [the child is usually okay about repeating]. Other times they [express] curiosity and questions about my hearing loss. (MU17.7)

I conclude this section with a quote from Brenda, which demonstrates how the alliance goes beyond shared experiences to the relational connection between any two humans: “I know that when I and the client get to know each other and communicate with each other the deafness part fades away. When we focus on the relationship” (BR 4).

**Use of sensory experiences to facilitate therapeutic understanding.** Rather than seeing their sensory impairment as a limitation, some participants described their disability as a *unique ability* in that they learned to rely on other heightened senses to interpret the here-and-now of a session. Nadine described how she tried to “pick up on non-verbals in other ways” and was able to hear “movement…happening,” even quiet movements that are traditionally experienced visually, such as the “rolling of eyes” (N9.1). Anna also used “body awareness” in her work and credited it to the ways that her history as a dancer taught her to be “aware of body cues” (A3.6). Sophia became aware of her ability to pick up on different cues while co-leading a group with a hearing therapist: “I feel like I did observe more than my co-leader…because my co-leader was attending to content” (S3.2). These examples demonstrate how the intuitive lived body – beyond the five senses – becomes a vehicle by which to further understanding of the Other, challenging the notion that one must be able to see and hear to practice depth psychotherapy.

**Mentoring and psychoeducation.** Participants also spoke about using aspects of their own experience with disability to psychoeducate patients who may be facing similar
hardships. For Jake, psychoeducation is about helping the patient learn “management” of disability (JK3), whereas for Nadine it was about “teaching clients to advocate for themselves” (N2.2). For Ellen, psychoeducation provided a positive experience in her work with children. She stated: “I feel that’s beneficial if kids that feel ‘different’ due to whatever circumstances brought them to therapy find they can talk to an adult who has been through some challenges” (MU 25.3). For Anna, psychoeducation was less about tools for success and more about developing a balanced view of life. She wrote: “My hope is that they can learn to see that their disability doesn’t have to define them; that they can see the glass as being half full rather than half empty” (A3.4). For many of my participants, providing psychoeducation felt like a natural role, especially when the patients themselves were othered or experiencing hardship. Such alliance with patients might also serve to reduce the therapist’s experiences of isolation that occur outside of the therapy space.

These are just a few themes that emerged when considering the conscious ways disability is spoken about and addressed in the therapy dyad, especially with respect to power differences. In the next section, I pay attention to the more unconscious elements that play out between therapist and client.

4.6 The Unconscious Dynamics of Disability: Transference and Countertransference

This section deals with a different aspect of the therapeutic dyad: that of transference and countertransference. Participant examples of transference often centered on client projections stemming from early experiences with otherness or disability. Other participant instances demonstrate how client reactions to disability suggested underlying diagnostic issues.

Client projections. Many participants made reference to the projections and
assumptions their clients made about them with regard to their disability. Often these projections existed even before the client entered the consulting room and frequently they stemmed from transference dynamics occurring in the current relationship. In the following excerpt, Octavia described how she used such projections in the service of the therapy.

In the end of our session – so we’re probably at the 47-minute mark of 55 and he says, he says, “I find it’s really easy to trust you.” And I said, “I’m curious about that, help me understand what is it about me, what makes me more trust worthy?” And he said, “I can’t imagine what it’s like to be blind and in a room with a big guy that everybody says is a criminal. And it’s just you and me in here and I don’t feel like you’re paranoid or afraid of me at all.” [I said,] “But you can’t see me. You don’t know what I’m doing.” So I actually expressed curiosity. [I said,] “What would I have to be concerned about?” And he said, “Well, as far as I know, nothing. But from everybody else’s perspective a whole hell of a lot.” So that was powerful for me to recognize how the perception is…skewed. (O12.2)

Being idealized like this was not an uncommon occurrence for Octavia; she recognized that she stepped into this role “just by virtue of being blind” and that while it was “gratifying” on some days she largely experienced it as uncomfortable, as she believed the focus should be on the client (MU13.5). When such idealization would occur, Octavia used herself as an “instrument” for the client’s transference, to “reflect on…familial dynamics” that might explain the transference (MU 19.1). She elaborated:

I said [to the client], help me understand what it is that you love. And she said, you can’t see me so you’re not judging me […] and so there was this kind of idealized role that I had stepped into just by virtue of being blind. (MU13.5)

In a world where superiors questioned her skills and trainees tried to prove their
worth, we can imagine just how gratifying it might feel to be validated and confirmed by patients. But Octavia did not see herself as a wounded warrior, or if she did, she wore it lightly rather than it being at the center of her identity. This excerpt speaks to the complexity that many of my participants experienced between wanting to be rightfully noticed and applauded for accomplishments and wanting to be seen apart from their disability.

Jaime’s experiences of transference, with both hearing and deaf clients, sometimes pulled at her heartstrings. In our interview, she described hearing clients who “[fell] in love with [her]” because she “[paid] attention too much” (MU 18.6). Deaf clients, on the other hand, frequently experienced a twinship with Jaime, believing they were the same: “[They will say,] ‘you’re deaf like me, you speak, you sign.’ [Or] ‘I can’t meet anyone else like you, let’s go out for a drink afterwards.”’ (MU19.2) As demonstrated below, sometimes Jaime found herself longing for a similar kind of contact:

When I meet people who are deaf like me […] I find myself sometimes attracted like we all do with some of our therapy relationships. And I’ve had to be on my toes about that and I think part of that is, wow I wish I could walk out the door and meet someone like that. You know?” (MU20.5)

This next example from Jake, where he describes a patient with schizoaffective disorder, connects to the previous excerpt with regard to transference issues. In an email, he wrote:

One patient, a woman with a schizoaffective disorder, stated that she felt more comfortable with me as a blind person, but later told of having been raped by a blind man while in college. The transference issue was right out there on the table. We discussed it and her reactions. Her deceased fiancé was visually impaired as well […] complicating things further. (JK2)

This powerful example illustrates how patients’ initial feelings about the therapist’s disability
can change over time and with respect to the alliance; this particular client of Jake’s might not have self-disclosed her experiences if she did not have some kind of feeling for the therapist, positive or negative.

In conclusion, Sophia reminds us that projections are an inevitable part of the therapy and that not all client projections are negative or need exploration:

When I ask them [to] say more about what it’s based on […] it’s always based on something they assume about me. But you know it’s like, that’s okay with me. If it’s working for the therapy, they can assume what they want. (Laughing.) If it works against the therapy, I’ll clarify. (MU18.5)

**Client reactions to disability as diagnostic clues.** For some participants, client responses provided insights into characterological issues or diagnostic cues. Melissa gave an example:

These [clients] will come across as being quite clumsy and/or intrusive in how they ask me questions about my blindness. For example – how long have you been like that? Or just walking over and patting my guide dog without asking first. I have also had the odd occasion where a client has brought another person into the session and hasn’t introduced them. I have sensed that there is somebody extra in the room and asked who is there. (MU 22.3)

Some clients vehemently denied reactions to Sophia’s disability; when this happened, she noticed that it was often connected to a psychological issue. Other clients who responded negatively to participants’ disability showed hints of narcissistic injury or traits consistent with narcissistic personality disorder. For these clients, making accommodations was experienced as a burden; they needed their therapist to be, as Nadine stated, “physically perfect” and without flaws (N8.1). Sophia described a similar phenomenon:
When clients with a kind of entitled narcissistic bent [...] approach the therapy it’s an imposition on them to repeat things. Versus a hardship. Versus somebody [for whom] it’s hurtful to repeat because it keeps it in their mind. [For the narcissistic client] I’m putting them out by needing more from them in order to communicate. (S2.7)

Moreover, when working with clients who are difficult to lipread and who are not willing to make changes, a loss of contact takes place. Sophia continued:

[These clients], they mumble [...] they talk too fast. They don’t pause. They don’t create opportunities for me to stop them and try to clarify things [...] then too much of my energy has to go into getting what they say and there’s less opportunity for responsiveness. (MU 8.2)

On the other hand, when her patients slowed down and spoke clearly, Sophia actually felt less attached to catching every word because the relational space between the two had allowed “more process” and “more spaces” for new material to emerge (MU 15.1). That Sophia was able to relax about not always understanding her patients contributed to the sense of expansiveness in the room. It may also have made space for transference and countertransference reactions to emerge.

For Anna, patient reactions to disability pointed less to diagnostic issues and more to relational issues. She described:

I used to strain to hear a client, a quiet client, thinking that it was only my problem hearing them and then realized that others also have a hard time with their quietness. So I use my heightened awareness to underscore the communication difficulty. [I might say something like], “You know, I’m having a hard time hearing you and I’m wondering if other people in your life also have a hard time hearing you.” And what
I thought I would hear is, no, not really. But in each case, they say, “Yeah, you’re right. People say that.” (A3.3)

**Therapist reactions to client responses.** Participants were also asked about their reactions to client reactions about their disability. A few participants had trouble thinking of examples, saying that their clients did not make negative comments or that they simply were not attuned to their own reactions. More often than not, participants discussed moments in their clinical practice where they felt counter-transferentially challenged by their clients with regards to disability. Jake stated that many of his countertransference issues arose when he worked with other patients who were blind (bringing up “neediness”) as well as those who were sexually abused. Alex described how he used to feel “pissed” when his clients reported drinking and driving and that it was hard to separate his feelings from the person’s behavior (MU 21.2). Over time, he was able to understand his countertransference in light of his own wish to drive a car. He stated: “Maybe [it’s] that sense of countertransference or maybe jealousy on my part. I wish I had what they had” (MU 21.1).

Jaime described a powerful experience of becoming angry after losing a favorite client with schizophrenia because the client’s mother decided that Jaime couldn’t work with her son. She recalled saying, “I said my hearing problem is not a problem working with your son. I don’t need to work with you” (J10). At that time, she remembered a red flag going up in her head, a part of her saying, “Oh, you have issues. This is something you have not resolved yet” (J10). Reflecting on this experience in our interview, Jaime described how, through supervision and her own therapy, she realized that the mother was dependent on her son’s need for her and that the mother was more bothered by her son’s independence and connection to Jaime than by Jaime’s deafness. She elaborated: “In hindsight, I should have been more compassionate and not gotten defensive and said to her, ‘What’s going on?’
Rather than focus on me” (J10).

Jake described working with a blind client who later became his supervisee. As a therapist he did not experience many countertransference reactions, but as a supervisor he felt stirred somehow by her presence. He stated:

Perhaps I feel some competition with her; perhaps I am frustrated by her youth; perhaps I am responding to her differences, race and sex; perhaps I’m responding to her clinical limitations; however, it does seem that my counter-transference is based on her dedication to me as a mentor […] I feel that my uncomfortableness with her is [about] her neediness. Apparently I have some of the same issues. (MU 20.6)

Grace described how she used to over identify with her patients, to project onto them her own thoughts and beliefs. She described:

Sometimes with the disabled client I would assume he feels the same way I feel when he faces discrimination or prejudice or hardships – but I quickly learned that is not always the case and I stopped allowing my experiences to get in the picture. (MU 21.5)

When working with narcissistic clients, those for whom it is an imposition to repeat, Sophia was aware that she felt “annoyed [and] less motivated to help them” (S3.9). She recognized this as “something to work with” in the therapy as well as through consultation.

To conclude this section, I provide a beautiful clinical excerpt by Octavia that highlights the intersection of transference and countertransference as it played out in her work:

Sometimes [clients want to] nurture me and this particular client was […] very much trying to gratify and appease me. Being hyper-compliant. And for me it brought about the experience of others. Others, my children. Or other colleagues. I found
myself becoming aggravated and agitated, as she was working to condone, comply, appease me. She wanted to make me happy. And for me I was angry about my blind — I felt it within myself. My own growing resistance to her need to appease me. To nurture me. To coddle me. And she wasn’t doing it overtly. But she was kind of — as I would offer an interpretation, she was going with me far too readily.

Interviewer: Were you able to talk with her about the stuff that would come up for you?

Octavia: Yeah, and so it went on for a few minutes in the session and then I paused. We had a moment of silence and then I kind of asked what was happening for her. I disclosed that I was aware of some feelings that were coming up in me and she [spoke about her mother having gone blind later in life] and her mother being very directive and dictatorial and her need to please her mother. And then it made sense to me. But I also recognized […] some semblance of projective identification.

Somehow I had taken on this kind of role within myself, I had recognized something had been called out in me. And I was angry. I went, please stop it, stop it, stop it, trying to appease me. I want you to listen and I want you to figure it out for yourself.

(MU 20.4)

This interaction resulted in a corrective experience for Octavia’s client in that she got to experience her therapist as a blind person who was not the same as her mother, who was not dictatorial or needing the patient to please her. For Octavia, recognizing that she felt “angry” about being blind was part of what allowed her to recognize the patient’s projection. As described in the next excerpt from Melissa, the work of identifying transference and countertransference is not easy and requires that the therapist spend time understanding what’s happening in the room:
At times I will pick up on projective identification, projective or disowned aspects of the client [that are then] are felt by myself. I am learning to differentiate these from my own responses that may be counter-transferential and need to be bracketed and taken away to work on later in therapy or supervision. (MU 21.1)

As seen in these excerpts, when transference and countertransference reactions about the therapist’s disability are discussed – explicitly or implicitly – a new world of understanding unfolds for both parties. Additionally, if therapists with disabilities discussed their transference and countertransference reactions with the larger psychology community, a greater understanding about disability biases might come to the forefront and challenge normative ideas about ability as well as spark future conversations at the intersection of psychology and disability studies.

4.7 Conclusion

The issues addressed in this chapter do not exist independently. Rather they are intertwined, often occurring simultaneously, as the blind or deaf therapist navigates their everyday life, inside and out of the consulting room. My results highlighted issues that were at the forefront for my participants, including accommodation difficulties, projections in the therapy, and coming to terms with one’s disability. Those who spoke mostly about accommodations seemed apologetic, as if they felt they should be talking about issues related to the therapy. At the end of our interview, Grace stated: “I know I deviated a lot from that since my issues are not with the clients but with the accommodations and the people surrounding in acquiring those. I hope that I was still helpful!” (G5.2). Reflecting on my own experience, I was surprised that so many interviews focused on accommodations. I had assumed that those further along in their training, with their degrees, would not have
had experienced so many difficulties around getting needs met. I had imagined their advanced degree would give them the power to get what they needed from their institution. This assumption speaks to my own misconceptions (and perhaps hope) that professional power meant less instances of discrimination; in fact, as participants stated, most often discrimination came from within the workplace rather than in the therapy space.

Results also suggest that relational spaces are created when patients and therapists grapple with their perceptions about disability within the session. When the experience of communication is circular or interrupted by the therapist needing repetition, rather than closing down communication, the process seems to open up underlying issues for the patient or in the room. As Sophia’s interview demonstrated, asking clients to repeat has the added benefit of getting them to slow down and become more aware of their internal processes.

Questions about the therapist’s disability go back to questions about the relational here-and-now, as illustrated from an excerpt in Octavia’s interview:

She brought in a recording and the title of the song was Blind Mary. And she played it for me and cried. And I recognized my own kind of grappling with that. She said, “You have made such an impact on me that when I heard this song it made me cry. So I recorded it and I wanted you to hear it.” For me, I was wondering [about] the significance of the blindness. But also recognizing the significance of the relationship. (O12.7)

Results also suggest that the more complex a participant’s relationship is to his or her disability, the more avenues by which they seem to explore patient questions and reactions to their disability within the therapy session. This line from Alex demonstrates what many participants have felt over the course of their lives: “I didn’t want my disability to be such a prevalent part of my identity in defining me in what I could and couldn’t do, although it did.
[...] Even though I didn't want to admit it” (AL12.1). Having a complex relationship with disability does not mean being without a sense of pride or identity; topics I take up again in the disability studies chapter.

4.8 Member Check Results

Select participants were given the opportunity to review their individual analyses and offer feedback. I had initially written this dissertation to include both individual and overall results; however this method quickly became cumbersome given all the interview themes. While waiting for responses, I decided to integrate my individual analyses into my overall results to condense the material. By the time I had made this decision, only one participant had gotten back to me. I reached out to other participants to let them know of this change and that their comments were still important to me and would be incorporated into the draft. I also stated that I would share my final dissertation when completed, at which time additional feedback would be welcomed.

Sophia stated that my write-up was “valuable” to her and that she felt I had captured

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8 As described at length in the methods chapter, member checks were only done with those interviews that appeared to have the most substance and depth with regard to the study under question. I’m well aware that it is on me, as the researcher, that not all interviews got equal representation; this is largely due to my novice ability as a researcher and that I took on too many interviews as well as my attempting to do interviews using a set up that did not always have the best connection. These issues are further discussed in the reflexivity chapter.

9 One person withdrew after reading their member check; this experience is discussed in brief (due to confidentiality) at various points in the next two chapters.
her experience through my description of “multifaceted and complex” issues. She agreed with my focus on “communication as complex act and possible therapeutic entity in itself,” and that my overall write up helped her to clarify her own experiences.

Jaime had a slightly different take. As she read her write-up, she sent me frequent email updates and finally the write-up attached with extensive comments. Jaime stated that she appreciated my comments but also felt I misunderstood her identity – she clarified that she does not and has never identified with Deaf Culture; rather her primary identification is “hearing.” Her comments aimed not only to correct my impressions but also to clarify by providing more information. Additionally, it seemed important to Jaime that I not have any ambiguities in my interpretation of her story. When I would wonder about a point of tension or complex issue, Jaime would respond with a straightforward answer, often one that, in my opinion, served to erase the complexity of the issue. Regardless of my impressions, it seemed important to Jaime that all aspects of herself be seen as straightforward. Jaime also clarified for me the relationship between her hearing-centric identity, cochlear implants, and past trauma, something I had not picked up in our interview. Additionally, she put me in my place – and rightfully I might add – when she questioned my statements about Deaf Culture. She stated “What do you know about Deaf Culture?” I know only a little from personal experience, though have learned much from my interview with her. Jaime also offered further insight into the love-hate relationship that I commented on at the end of her individual analysis. She stated:

One insight in relation to the “love-hate” relationship with my deafness – is in fact, not my deafness but the impact of the trauma that brought about the deafness and my struggle to separate the two…but that’s a losing cause. They will always be intertwined.
She also asserts that a fast-paced talking style is more about her being a New Yorker than about any anxieties she may have been feeling. Finally, Jaime did not seem pleased with some of the direct quotations that came from her interview transcript. I wonder if she might have responded more positively if she had read the entire transcript rather than just my write-up. After talking with my advisor, I decided not to send the entire transcript to participants because it seemed unnecessary and I worried participants would feel overwhelmed with having to read and respond.

Octavia was “remarkably impacted” in reading her reflection. She made a few clarification comments and then stated: “You spoke to so many of my truths and offered healthy curiosity that provoked my own introspection […] I am likely significantly defended around the truths most pertinent to my blindness and generating humor is my means of deferring to beat others to the punch-line. Your acknowledgement of my theoretical orientation and its relationship to my experience of blindness is beautiful.”

Grace stated that I did a “good job” summarizing her experiences and that she appreciated the ways I “honor[ed] [her] story.” She clarified that while a “lawsuit” was on her mind, she never threatened to actually file one or stated that she would so. Rather, she was trying to suggest that a lawsuit would have been her last resort if nothing was resolved with the sensors. She added: “Thankfully, it did not get to that.”

Alex also sent a few positive comments in response to his write-up, with a clarification issue. I include part of what I wrote to him to illustrate the misunderstanding:

That Alex has gone through the process of trying on multiple identities gives him the ability to compassionately empathize with patients also exploring with different presentations of the self. Moreover, when clients make positive projections about Alex’s disability, Alex tries to pay attention to what is going on for them underneath
the compliment. This kind of paying attention, if you will, allows him to not get overly attached or over-estimate his therapeutic skills.

Alex responded that he had a negative reaction to that statement but also stated that he was not sure he understood my reference. He clarified; “I think I do get attached to my clients in a professional constructive way in wanting to help them address their concerns as quickly as possible but also think I have an awareness of healthy therapy boundaries as well, if that makes sense.” Reading Alex’s comment was helpful for me in terms of understanding how I could have been clear. What I meant by that comment was not to suggest an unhealthy attachment to patients but to suggest that he does not embody the wounded warrior or supercrip image sometimes projected onto him by patients.

The member checks made me aware of how the material must come across when reading it as a stand-alone document, apart from the interview transcript – and, for some participants, after a year has passed from the interview itself. When reading one’s own words it is not uncommon for participants to feel vulnerable or exposed. I also imagine, given the power differential in terms of career status, participants may have felt uncomfortable giving more direct feedback because I am a graduate student and still learning. That I am a researcher who shares a disability identity (deaf) with some of my participants may have also impacted how forthright participants were in responding to my member check questions. The largely positive responses here also made me wish I had invited more participants to participate in member checks.
Chapter 5
A Disability Studies Analysis

5.1 Interpreting Results through a Disability Studies Lens

Many of the themes that emerged from my IPA analysis reflect topics frequently discussed within disability studies, and I devote this chapter to those issues with the aim of drawing important connections to the psychology field. In addition, I consider how my interview design, setup, and method of analysis were impacted in terms of being a deaf researcher interviewing participants who were deaf or blind.

Claiming and rejecting the supercrip narrative. A common assumption made by nondisabled people is that those with disabilities have the power to “overcome” impairment and to become “normal,” just like everyone else or even “better” than everyone else (e.g., blind therapists having special powers of perception). This is known as the “supercrip” phenomena, often perceived as the opposite of a pitying response. Amanda Booher (2010) quoting Joseph Shapiro states: “A supercrip […] is a disabled body […] that has seemingly achieved ‘the constraint of conformity’ and superseded its low ranking to appear normal and acceptable” (p.72). In his book Exile and Pride: Disability, Queerness, and Liberation (2015), Eli Clare gives a few examples of the supercrip: “A boy without hands bats .486 on his Little League team. A blind man hikes the Appalachian Trail from end to end. An adolescent girl with Down syndrome learns to drive and has a boyfriend…” (pg. 1). One of the difficulties with the supercrip narrative is that it suggests that disability is something negative, something wrong, and does not separate impairment from the conditions by which society disables some individuals more than others. Saying that someone achieved something “despite” her or his disability suggests that the disability (rather than the physical barriers and negative
social positioning) stands in the way of achievement and happiness. “Overcoming” language, or ideologies, support the idea that one must somehow negate or counterbalance her/his disability to achieve social recognition and success (Knoll, 2009).

Not unlike the examples Clare provides, some of my participants were either perceived as having supercrip qualities by their patients or attributed such qualities to themselves. Sophia described: “Some clients feel I’m going to understand them better because I’m going to know what it’s like to be left out. I’m going to know what it’s like to have hurdles, to overcome. So some clients may feel it’s going to work for us” (MU 17.1). This is just a small example of the supercrip narrative: her clients are projecting fantasies because they believe she can not only relate but that she also possesses “something extra” in her experience.

Most often the supercrip label is given to a disabled person by nondisabled people as a means of normalizing them, perhaps as a way for the nondisabled to avoid their own uncomfortable feelings about disability. But what happens when the disabled person takes on this role? In other words, some elements of the supercrip narrative are unavoidable – my participants have achieved an elevated professional status and completed advanced degrees while being members of a group for which, in the aggregate, unemployment and poverty are common and educational attainment is low. The narrative of overcoming and inspiring is difficult to avoid in this context, and it can be one tool in a disabled therapist’s arsenal for navigating an ableist world.

For Grace, the supercrip narrative is sometimes a survival strategy. In her interview, the therapy room figured as a space where she could be heroic in contrast to being held back by lack of accommodations in other aspects of her professional life. Her colleagues and superiors were experienced as difficult while her clients became the saviors. On an implicit
level, Grace seemed to relish the positive idealized attributions received from patients and colleagues. She made references to “having more hours” than anyone in her program and to having many “meaningful moments [with patients] centered around [her] getting it” (MU 13.3). Another aspect of Grace’s interview that called forth a supercrip narrative was her tendency to speak in absolutes: “They always offered to talk louder and I never had to tell any of them to repeat or speak clearly or uncover their mouth”; “this is with all clients”; “it was automatic for all of them,” and so forth (MU 13.3). The use of absolutes here, even if Grace was unaware of it at the time, indicates that she may have needed to generalize positive experiences with patients as a protective factor, given the difficult relationships she faced outside the therapy room. It is not surprising that the positive aspects of the therapy relationship came to the forefront for her, rather than its messy, nuanced, complicated, or even neutral aspects. When one experiences so many hardships outside of the therapy, there is little space for hardships within. It is also possible that Grace simply chose to talk with me about the positive aspects rather than the negative, perhaps because we had just met or even to reassure me that I could also have positive experiences with patients.

Other participants had a complicated relationship with the supercrip narrative. Alex was able to recognize positive projections from clients while not over-identifying with them:

The hero complex of, oh, you’ve done so much. Wow, you’ve overcome so much.

You’ve not let your challenges defeat you or be a barrier […] I just kind of let it go in one ear and out the other […] because I understand that that’s how a lot of people react to individuals. You know – there’s probably some truth to it. (AL4.1)

Rather than buying into special nonverbal powers, Alex questioned these beliefs. He further elaborated: “Sometimes I think my clients may think I can’t see but I can hear better than other people. Or I listen more effectively, and I don’t necessarily agree with that” (MU18.3).
Listening was a skill that had been cultivated from his therapy training rather than his otherness, and trust with patients was built through the alliance rather than supercrip projections. Alex’s early experiences of trying on different identities with respect to blindness (e.g., trying to pass as a child, experimenting with different self-disclosure styles) shaped his relationship to disability.

Participants who were less likely to see themselves as having overcome disability seemed particularly in touch with the complexities of isolation and loneliness. That is, part of what it means to accept disability is also what it means to be in touch with experiences and feelings that are simultaneously discouraging and empowering. For Alex, being his own advocate was necessary, empowering, and also isolating. His job as the director of a UCC came with its own kind of loneliness. He stated:

I don’t even know any other individuals that have physical disabilities of any type that I would have immediate access to or could relate to. I would say there’s definitely a loneliness in the profession. I would say that’s true. (MU3.3)

Octavia described what it is like to challenge the notion that she has a special gift because of her disability:

Yeah, on some days it is amazingly gratifying. And I have to be cautious because, you know, what am I getting from this? Because there are days where, yeah, thank you for validating me, confirming me. But my patients should not have to do that. Definitely should not have to do that. And then on other days, it can be — I can be challenged by it. And sometimes [...] I use it to kind of reflect on maybe some familial dynamics where we’ve idealized something or someone. (MU19.1)

Given all the struggles that my participants faced, it is not surprising that some may comfortably wear the supercrip narrative – in some ways it serves to protect them, to an
extent, from discrimination as well as to keep at bay repressed fears and thoughts about their disability. Yet, as I draw attention to in the reflection chapter, repression of internal fears and uncomfortable feelings seems damaging on a large scale, as it further perpetuates the supremacy of the nondisabled body or mind as the ideal.

Rejecting disability: surviving in an ableist world. Denying any significance of the experience of disability is connected to the supercrip narrative in as much as it is still about being “normal.” For example, Nadine stated that her disability did not impact her work with college students because she came from a “very diverse campus” with “marginalized students” (MU13.2), and thus her patients would have already seen and experienced otherness. She also believed that her therapeutic orientation kept her disability out of the picture: She stated: “If we’re working in a cognitive behavioral model, the student sets the goals […] my disability is not going to interfere in any way with what they’re going to get” (MU23.5). It seemed important to Nadine that her disability not impact the therapy. However, our interview highlighted moments when her disability was very much present, as seen in the example she gave about a client’s need to work with “somebody who was perfect…physically perfect” (N6.2).

When asked about what this experience was like, Nadine appeared to downplay her emotions: “I know that it happens […] what you have to do is kind of separate yourself and try to understand the dynamic and that it’s not personal. I’m an object, I was an object to that person” (MU 8.10). The distancing of self from emotions also occurred in her descriptions of interactions with clients. When clients asked Nadine about her disability, she would turn the focus back on content rather than exploring the meaning behind their question, as seen in the following excerpt:

I have had rare occasions where clients wanted to talk about the disability or wanted
to talk about other things and it’s to distract, you know, it’s to distract from focusing on them, so I said, you know, really this is all about you. Let’s focus on you now.

(N8.2)

Reading this again, I can see why Nadine would choose not to focus on the question, as doing so might make her feel vulnerable, unsafe, or, as she states, distract from the client’s presenting concern. Additionally, I sometimes had the sense that Nadine’s experience of her disability was displaced onto her service dog. She stated:

You know, I think the disability is not interfering anymore, or not affecting. Either that or maybe [the clients] want to be with the dog. […] In terms of being a therapist, really not that many [challenges]. To some extent it may have to do with the fact that I have a service animal. (N12.1, N5.5)

Moreover, Nadine’s service dog, which helped her to accommodate to a world that does not accommodate her, played a big part in the way she spoke about her personal and professional identity. Consider the following three excerpts from our interview:

And you know, I’ve had a few clients who, I, um, I conceptualize as psychotic, and you know what she does? She has a bed under my desk and she doesn’t even go near them. She goes in her bed. And rolls up into a ball. She doesn’t interact with them. (MU22.2)

When I have students that are depressed that come in, she gets one of her toys and puts it in their lap and sometimes she sits beside the client. Sits beside them, near the chair there that they sit in. So it’s really, you know, I think it’s really pretty straightforward and having that animal has been very helpful. (N5.3)

You know, and sometimes some clients of my colleagues, you know, they’re seeing other people in the counseling center, they know I have a dog. And when they see
my office door open, my colleagues often bring their clients in so they can say hello to [name elided]. It’s very interesting. (MU30.1)

Nadine’s service dog seems to offer signals that could help Nadine stay safe, to contribute to the therapeutic environment, and to facilitate connection with peers. But I find myself wondering: who does the dog benefit most? Did Nadine feel taken advantage of by colleagues who would visit her office to see the dog? What did she mean when she described this behavior as “interesting”? Did the presence of her dog help Nadine feel more accepted at work, or more liked? While the function of a service animal is to help mitigate the negative impacts of being blind in ableist world, Nadine’s story suggests that her dog’s duties extended to the therapy room and may even connect to Nadine’s self-esteem as a therapist. Indeed, she seemed to be noticed more for the dog than for herself, both in and out of the therapy space, and she may have cultivated this reaction as a survival mechanism or simply because she did not mind if her dog got a lot of attention. The dog was also a focus of our interview and was frequently cited in response to more challenging questions; in some circumstances, it may have been easier for Nadine to talk about her dog than about her own struggles.

We cannot really know Nadine’s underlying feelings and motivations with respect to this topic, so I am hesitant to offer up these thoughts at the risk of grossly misrepresenting or pathologizing her experiences. From this interview it appears that Nadine finds safety and comfort in the supercrip narrative – and having done so myself, I can relate to that need. In choosing to reveal only certain aspects of herself, Nadine, like all my participants, was asserting power within the interview dynamic. Yet, what she revealed suggested that maybe she did not feel as comfortable getting in touch with more complicated feelings, perhaps
because we were speaking at a public conference or perhaps because we did not have a lot of time to build a deep alliance.

5.2 Disability Studies as Methodology: Crippling Traditional Interview Structures

Throughout the process of interviewing and coding, I tried to meet the access needs of my participants while also honoring my own access needs. I provided consent forms in large print for participants with visual impairments (and also offered to provide an audio-recording of the form). I also offered multiple interview formats with the aim of increasing accessibility: face-to-face, Google Chat, Skype, and Purple Communications videophone service. As stated in previous chapters, while these different interview formats allowed for accessibility of my questions, access to interview rapport and depth was not so easy to create, especially in those interviews that occurred via email or chat. Most interviews went well and participants seemed at ease and engaged. In a few interviews, however, my attempts to make the space accessible backfired. Sometimes it was the fault of technology (e.g., Skype blipping out); in other cases it was because I had not adequately thought through the set up. For example, I interviewed Nadine in a hallway – her preference – rather than in a more intimate setting.

While I attempted to make my project accessible, I also participated subconsciously in the ableist view that face-to-face interviewing leads to richer interviews. Chris Mann and Fiona Stewart (2000) discuss this view in their article, *Internet Interviewing*.

[The initial attraction of interviewing online] might not be enough to sustain [participants’] ongoing interest without the impetus of enthusiasm and focus that can be injected in the face-to-face setting by a skilled interviewer who is “firing on all cylinders.” Online, interviewers may not be able to offer enough verbal “dazzle” to
compensate for the charm or charisma that can be so effective face-to-face. (p. 93)

While I do not believe I was particularly skilled or “firing on all cylinders” in the face-to-face context, I do worry that I did not do enough to draw out my online participants.

Additionally, the notion of “firing on all cylinders” is an ableist idea, assuming an ease with in-person conversation that disability complicates. If online participants did not respond to my follow up questions after I had sent two emails, I did not contact them again out of respect for their time. At the same time, I think that for other participants, online interviews felt safe to them. For example, Grace requested a Skype rather than face-to-face interview, even though she did not live far from me. If I were asked to participate in an interview like this I would probably prefer email as I enjoy writing and might feel safer expressing vulnerabilities on the page than to a stranger.

The lack of depth in some of my interviews points to the co-created dynamic that occurred between my participant and myself. For example, I could have better anticipated interviewee needs via Internet communication. Donna was brusque in her initial email asking me to contact her again in the summer because she was “too busy”; rather than interviewing her anyway, I could have decided to let that one go. Some participants who were interviewed via email or chat participated in that co-created dynamic by sending responses of just a few words. To argue that the dynamic is co-created is not to put fault on any one person but to break down the power differential between interviewer and interviewee. Depending on the interview setup, power might lean one way or the other. That is, in an interview that occurs via email, participants can choose to respond or not at their own speed, which would be harder to do in a face-to-face interview.

In the remaining pages, I analyze the ways in which disability played out in the interview design and setup. An analysis across transcripts resulted in the following broad
themes with respect to this topic: rapport-building around shared experiences; the role of repetition in disability interviewing; challenges using multiple modes of communication; discerning meaning in interview transcripts; and meeting the access needs of participants. Additionally, I offer thoughts on how paying attention to access needs shaped the research project itself.

**Building rapport: Disability on both sides of the screen.** In my interviews, rapport was often developed around experiences of disability, self-disclosure styles, and general conversation about our respective lives and careers. Witnessing how participants talked about their disability with me offered a glimpse into how they talked about it with clients. When Octavia remarked on my style of listening, as a process comment in the interview itself, I could envision her talking to her patients about being blind as it played out in the here-and-now. Additionally, my interviews suggested that having these conversations with me may have reduced some loneliness – I know I certainly felt less alone in my experiences after each interview. When Jaime talked about the exhaustion of lipreading and I joined in, she got more animated and alive, which may suggest she felt connected to me during our interview. Thus, conversations about shared experiences of disability are necessary in contributing to knowledge production about psychotherapy and disability, especially with respect to creating an interdependent alliance between the psychology field and disability studies.

**Repetition as access.** As seen across most interview transcripts, especially those with d/Deaf participants, questions and statements were often repeated for the benefit of my participant or myself. In my interviews I noticed that occasional repetition allowed for vulnerability and trust to develop between participants and myself, such as in the following example from my face-to-face interview with Sophia:
I: Do you have any questions before we start? Is my volume okay?

S: Say again.

I: Can you understand?

S: Yeah.

I: Let me know if you can’t and I'll do the same. My first question is, can you tell me about why you went into psychotherapy?

S: I have a habit of repeating the question to make sure I have it.

[Later]

I: Do you see students who are disabled as well? Clients who are disabled?

S: Say it again.

I: Clients who are disabled as well?

S: Can you show me the word? Okay.

Other times, the act of repetition seemed to stop the flow of conversation. For example, I would sometimes receive “yes” or “no” responses from participants after I asked for clarification. This would be followed by silence, and then me trying to pick up the conversation again. For example, in my interview with Nadine, I frequently asked for clarification. We were in a hallway and I was feeling a little anxious about her preferred setup. She would reply and then stop talking. This style did not allow for an easy co-created conversation and reflection. Rather, it felt like closure, like she was waiting for me to respond again. When I had to focus on intensely understanding every word, the psychic and embodied space actually seemed to shrink. This had a different qualitative feel than with participants who responded by rephrasing the statement that I misheard or stating it again and then continuing their line of thought. The feeling here is one of “access intimacy” – when someone not only gets my access needs but also participates in creating accessibility.
Mia Mingus (2011, para. 4) describes it as follows:

Access intimacy is that kind of eerie comfort that your disabled self feels with someone on a purely access level. Sometimes it can happen with complete strangers, disabled or not, or sometimes it can be built over years. It could also be the way your body relaxes and opens up with someone when all your access needs are being met. […] Access intimacy is also the intimacy I feel with many other disabled […] people who have an automatic understanding of access needs out of our shared similar lived experience of the many different ways ableism manifests in our lives.

While participants did not explicitly discuss their impressions of access in terms of the interview, those who responded positively to the member check might have done so because they felt comfortable with me and experienced such access intimacy.

**Benefits and challenges to multiple modes of communication.** When collecting data through digital interfaces, like Skype, the data itself changes. From the outset of my project I was focused on making interviews accessible while also thinking about how accessibility could be furthered through my research. An upside to videoconferencing is providing access through the Internet/computer; participants can be interviewed from the comfort of their home without having to spend any funds or worry about mobility issues. The downsides to using technology include inevitable glitches that get in the way of smooth communication and alliance. For example, about five minutes into my interview with Grace, the Skype screen froze. Various attempts to fix it, such as restarting, didn’t work, and we ended up doing the interview through typing/text-based communication. Grace’s face was frozen on the screen for most of the interview. While it helped to have a visual, it was also distracting. Additionally, the time it took to restart cut into our interview time and also may have contributed to a rushed rather than relaxed interview feel. That Grace could not see
what I was doing while she was typing, that she may have imagined what I might be doing (e.g., is interviewer bored and checking email?) or how I might be responding (e.g., weird facial expression, nonverbal expression of empathy) probably created a sense of distance within the interview. I, too, found myself wondering what she was doing on the other end when not typing.

While most participants tolerated these glitches, others found it annoying and distracting. Anna commented at a few points that my face was flashing on her screen and found it difficult to stay focused. This glitch might have reduced the seriousness of the interview and may explain, in part, why Anna took a social call in the middle of our interview. On the other hand, there were positive aspects to the digitally mediated interviews too. While I was interviewing Bella, her dogs came up in the background and we had a brief chat about dogs. After this moment I noticed that the flow of our conversation seemed easier – this rapport may not have happened if we had interviewed face-to-face.

Other challenges also emerged in utilizing both screen-based and text-based communication. In my interview with Anna, we alternated between typing, speaking into the camera (lipreading) and using ASL – and sometimes all three. The following is an example of what this looked like in the audio-transcript coded by Christy:

A: I think in a way it has been defined who I am. And harder to blame influence. My therapy (indistinct). I have come full circle, treating it as a negative to now be okay with it.

I: Can you say more about that?

Anna: (Unspoken response.)


A: (Unspoken.)
I: Okay. Can you tell me about a specific — (typing question).

This transcript is confusing and jumbled without the text-based transcript to read alongside; yet, when looking at the text-based communication alongside the transcript the meaning is still sometimes unclear and/or fragmented. The screen recording does not fully recreate the interview either: it allows me to access what Anna said but I cannot access my own voiced/ASL contributions.

My interview with Anna highlights how the actual experience of the interview is extremely difficult to recapture or transcribe. In her article *Still Life* (1996), Deaf researcher Brenda Brueggemann discusses this difficulty, using the example of a qualitative interview with a participant who communicated using both speech and sign. Months later and miles away from the participant, Brueggemann struggled to try and make sense of her participant’s meaning. Similarly, communication with Anna was not always transparent; at times I would be responding to something Anna had said before, but she interpreted it as connected to something she had just typed. This style of communication highlights how normal experiences of time and conversation patterns are challenged and crippled in disability contexts.

My responses to interviewees’ comments also varied with my interview methods. In person I often responded with “mm” or some other noise to encourage them to stay in that moment. But over Skype it is harder to create that effect of being present, at least for me given my reliance on non-verbals and visual cues. When Anna and I had technical difficulties and my computer screen started to flash, I offered to turn off my screen as so not to distract her. But she quickly reminded me that she needs to lipread me and preferred that to typing. So we continued even with the glitchy screen. This was not a perfect interview and I wish I could do it over, but at the same time, I appreciate how the difficulties here illustrate the
importance and the complexity of navigating individual needs when doing interviews.

**Time lapse with online interviews.** Another challenge with using Skype interviews was a time lapse where it seemed like participants and I were responding to different things. In order for both of our access needs to be met, my blind participants frequently had to type out responses (because it is hard for me to lipread over a computer screen) and I had to speak (because they could not read the words as I typed them). When possible, I typed my own questions in order to have a transcript of what I was contributing, though this was not always possible. Consider the following example with Bella:

B: I do not want to direct the client on my path but rather on his/her path

B: That is very hard since often the decisions that one makes is quite poor

[…]

B: I am not a very good speller (Laugh)

I: That’s ok!

I: How do you work with this challenge?

The way this transcript is written out suggests that I was asking her how she works with the challenge of not being a good speller! But I was actually asking her about challenges of having a sight disability. While this may seem like a minor issue, over time the compilation of such moments may negatively impact the interview flow.

The availability of the time stamp in Skype interviews allowed me to see how much time had passed before participants responded. I noticed that, unlike in my face-to-face interviews, Skype participants started to talk or type right away, almost as if they were being timed. This might have created some anxiety in participants, especially if they thought I was waiting for them to respond. These participants seemed more likely to respond right away and then backtrack or correct themselves. For example, when I asked Grace a question that
had many parts, she responded via Skype chat a second later with a few words, the beginning of a thought that would not necessarily make sense as a stand-alone comment or spoken aloud. That said, typing right away can also signal a way of thinking about something and doesn’t necessarily mean a faster thought process. This speaks to the different styles of online communication and how such styles can impact interview alliance and flow.

**Nonverbal reactions.** Gauging non-verbal reactions online presented its own unique challenges, especially if the screen was blurry or if the participant was looking down at the screen to see the keys. As I mentioned earlier, Bella had to look closely at her keyboard to see the letters, which meant that I could not see her face very well. In essence, we traded one kind of accessibility – the benefit of understanding via typed text – for another – that of being able to see each other’s faces. Bella communicated nonverbally by gesturing with her hands and head, as seen here:

B: I worked for a women’s center where there were a bunch of strange people. They wanted total control, which was in my mind totally counter to the mission of a women’s center. So I had to have enough confidence to challenge (taps head.)

I: I noticed you tapped your head when you were recalling that…what was that about?

B: It was very stressful!

In other interviews, participants expressed emotions through the use of emoticons or capital letters. This excerpt comes from Grace’s interview:

I asked the clinic director to designate a room for me in which the cameras will be mounted shoulder length so I will be able to lipread […] since I cannot lipread from the top of someone’s head: :) The response was that - they cannot do that because it is not AESTHETICALLY PLEASING to the room (G1.2).
The use of the smiley face emoticon is interesting given that this was an upsetting and stressful time for her. We can wonder how she might have presented this information if we had met face-to-face; perhaps she would have laughed instead or used a different means of expressing her emotion.

**Attunement to language differences.** American Sign Language, or ASL, has its own unique grammatical structure and syntax that is very different from spoken or written English. For example, in ASL the object is usually signed before the subject and verb, as in “store-I-go,” whereas in spoken English one might say, “I’m going to the store.” With participants who communicate in ASL, such as Jaime, Anna, and Brenda, it is important for the researcher to know these differences when transcribing interviews. The following example from my interview with Jaime demonstrates this importance: “I ended up doing my student teaching in [big state] at X. The high school, X. They put me to teach math. I’m not math. (Laugh) I’m deaf culture, deaf culture shock” (J12.5). Someone who does not know the grammatical structure of ASL may read this and think the person is being unclear. For example, in ASL, signing, “I’m deaf culture, deaf culture shock” makes sense but in spoken English we might say, “I’m not skilled at teaching math; I teach deaf culture and it was a shock to have to teach math.” This speaks to the need for interviewers to have some familiarity with participants’ first (or even second) language. Additionally, when Christy transcribed my interviews, she did not know whether to type little d or big “D” when typing the word deaf because of the inaudible distinctions that occur in language. Reading through the transcript, I had to decide what Jaime meant – was she referring to audiological deafness or Deaf culture? Her member check response let me know when I was incorrect in trying to decipher her meaning. There is a stark difference between big D and little d, so knowing this information is helpful. This was one of the contexts where the member check proved most
useful.

**Ethical challenges with research design.** Ethical challenges arose alongside access challenges in some of these interviews. For example, Nadine requested to be interviewed outside the room where she was scheduled to present at a conference because there was not a lot of time in between panels. I felt torn between asking her if we could move to a private room and respecting her wish to stay right there. I tried to calm my anxieties, as I knew they would impact the interview. We ended up moving a table away from the main part of the hallway and pulling together two chairs. This space was better than interviewing in the busy entrance but it was harder for me to hear, and I had to ask for repetition more than usual. This is another example of how meeting the needs of participants, as well as my own, shaped the research project. It also highlights how, as Margaret Price (2012) states, “accessible methods are not concrete tasks to be fulfilled” (p. 167) but require flexibility on the part of both interviewer and participants. In other words:

> Accessible research designs often must be implemented on the fly, and sometimes have disappointing results…the [disability studies] researcher cannot approach a participant assuming that he or she learns, speaks, listens or makes sense of his or her experiences in a particular way. (Price, 2012, p. 167)

In retrospect, I should have re-scheduled the interview for a later date, even if it meant traveling to her or using Skype. This learning experience also taught me about the importance of having strong boundaries around interview spaces and not being afraid to be assertive in order to maintain integrity to the interview setup. And although my instinct was to prioritize the access needs of my participants, I also needed to respect my own access needs.

While not directly related to ethics, I noticed that my interview analyses for those
participants who were videotaped highlights my strong preference for the visual over the auditory. A disadvantage to not being able to hear tone very well is that I over-read textual meanings in the absence of visual information. As I read through transcripts, I sometimes had difficulty discerning how participants might be feeling. When Nadine talked about how she made herself an object to the client, I thought she sounded a bit distant. Because I could not videotape this particular interview, I could not rely on the visuals to cue me into how she might be feeling or to interpret the nuances of meaning. That she seemed far away in that moment might well be a function of the text; she may have just been speaking matter-of-factly. Knowing that video taps into my strengths will inform the method by which I conduct future research projects.

**The temporality of disability access.** An aspect of disability studies methodology that often goes unaddressed is that of temporality and the experience of time for people with disabilities. Rather than moving in a normative, linear fashion, for people with disabilities time expands and contracts according to participants’ access needs. Sophia and I had to repeat multiple times, referring back to things we thought the other person had heard but hadn’t. A linear structure existed for the interview itself, in that it started at a certain time and ended at a certain time, but the dynamic of the conversation was circular, tangential, and frequently backtracked. In my interview with Anna, using Skype, ASL, and speech resulted in a patchwork transcript that I imagine may seem messy or confusing to a reader without a hearing loss. In some instances, the transcript was also messy and confusing for myself in trying to decipher after the experience. This creates an experience where interviews cannot be as easily “checked” by others who do not share the crip experience of the interviewer. When traditional interview structures are cripped, as is the case here, expectations about what counts as “correct” qualitative research becomes challenged. The researcher is no
longer in the position of knowledge, verified and supported through hierarchical institutional structures; rather, knowledge and meaning-making are co-created by the pair engaging in conversation.

As already stated, trying to make interviews accessible across a variety of domains had an impact on the meaning and shape of the research project. In offering a variety of interview mediums, I got a lot of participant responses. Because I offered online video interviews, participants did not have to leave the comforts of their home. Participants who were blind used screen readers and participants who were deaf either signed or used the chat function. Yet I wonder if there might have been some ways in which I tried to be too accessible, or did so in inappropriate ways. Because I was offering multiple modes of communication for my first full scale qualitative study, the project often felt unmanageable and with too much data. In trying to make sure that all voices get heard, rather than using only those interviews that I felt were strongest, a certain kind of depth gets lost. And my decision to do member checks to ensure that the voices of disabled people get heard did not result in a positive experience for everyone. One of my participants chose to withdraw after reading my summary of their interview; she said she did not finish the write-up and would not provide any details about why she wanted to withdraw. It is possible that this person felt vulnerable in reading about their own experiences. It is also possible that I may have tried too hard to represent her experience and in doing so misrepresented it.

In a write up of five member checks, qualitative researcher Julie Carlson (2010) demonstrates what happens when the researcher has not thought through the boundaries of a member check: participants feel exposed, uncomfortable, may edit the entire transcript to their liking, or may shut down entirely. Moreover, what a researcher intends to happen with a member check may not be what participants desire. As Lori Koelsch (2013) states:
Although it might be the researcher’s goal to focus on the accuracy of responses, participants in research projects might have other goals such as gaining sympathy from the researcher, protecting themselves (or others), rationalizing their behavior, or many other possibilities. (pg. 171)

A participant withdrawing also has significance when considering a disability studies framework, given the additional power dynamics; that is, not just interviewee/interviewer but also perceived beliefs about impairment (e.g., participants may have sized me up to decide if I was more or less disabled than them). A participant may choose to withdraw as a way of asserting power over the interviewer or, as we have seen, to maintain the supercrip image as a defense function against being vulnerable and further disabled by an ableist society – or even an unconsciously ableist research design.

5.3 Conclusion

This chapter has highlighted some of the issues that arise when interviewing participants with disabilities while trying to adhere to a disability studies methodological framework that values participant experiences, provides multiple forms of access, and crips traditional research structures. By and large I think my participants felt heard and respected throughout the process; however, as I learned, when both the researcher and participant present with a disability certain challenges come to the forefront that cannot always be anticipated in advance (e.g., alternating between multiple forms of communication methods). To ensure that participants get equal representation and attention from the researcher, best practices might include troubleshooting some of these issues in advance. In addition, best practices might also include conducting focus groups in the spirit of emancipatory and action-based outcomes such that participants can learn from one another about different
views and experiences of disability, gaining support as well as coming together to educate the larger psychology community.
Chapter 6
A Brief Reflexive Analysis

6.1 Introduction

Throughout this dissertation process I maintained a reflexive journal, a key component when doing qualitative interviews such that the researcher can explore biases throughout every step of the process and trouble the relationship between her own sense of self and that of her participants. This brief chapter addresses the co-created nuances that occurred in every step of the research design and interview as well as the varying emotions and anxieties I felt throughout the research process. The following issues resulted from the co-created dynamic that took place in the interview process, as reflected in my journal. Rather than being seen as self-critical, these are issues that I hope future researchers, myself included, will take into consideration when designing projects that either focus on participants with disabilities or that want to utilize a disability studies perspective. I also discuss implicit themes that emerged from my coding process with respect to reflexivity.

6.2 Interview Reflections

Demographics and selection criteria. That most of my participants were women raises the question as to whether the negative experiences they had were connected to their gender, not just their disability. Nadine shared a story about a male supervisor who told her she would not achieve as much as the rest of her cohort; it is possible he might not have said that to a male student with a disability but perhaps have taken on a mentorship role or encouraged him to “overcome” his limitations. Additionally, I did not ask participants to share other aspects of their identity, such as race; an unfortunate omission. Learning how
participants experience disability in conjunction with other forms of difference is important in understanding how marginalizations intersect. While I cannot speak to the class background of my participants, growing up with resources and family support offered me financial privileges that I imagine some of my deaf participants did not experience. Comparatively, d/Deaf participants immersed in Deaf Culture had the privilege of being part of a community of people like them, something I did not experience growing up.

**Analysis of interview questions.** A few of my interview questions seemed confusing to a couple of participants. Two people asked for clarification and one participant, who later withdrew, wanted to save what they perceived as the harder questions for later on in the interview. Looking inward, I think I was driven to some extent by a desire to elicit responses that would reinforce my own beliefs that disability is not an all-positive or all-negativa experience, but nuanced and complex; it is possible that my questions conveyed such complexity without being clear. Another researcher might have asked fewer open-ended questions, or even just one question, “What is it like for you practicing as a therapist with a disability?”

As interviews progressed and I made reflexive notes, I became aware of the hugeness of this dissertation project. Fourteen participant interviews occasionally left me feeling uncertain as to whether I was doing justice to the material at hand. In fact, at times I felt a bit rushed (especially when internship interviews intersected with the coding of this dissertation) and, looking back on that time, I could have asked for more help from my dissertation committee with regard to deciphering themes. That I did not is likely the result of feeling the need to figure it out on my own, a belief that stems from my own experiences with disability. Writing this, I am reminded of Grace saying she had more clinical hours than anyone else in her program. I do not know whether that was true for me but I am aware of
the ways in which my drive to succeed both helped and hurt me, a topic I further explore in
the autoethnography chapter.

Throughout the process of interviewing, I experienced a range of feelings: from joy
and excitement to frustration and annoyance. I sometimes wished my participants would talk
more about psychodynamic processes (my personal interests); sometimes felt frustrated
when online participants didn't expand on my questions; sometimes felt horrified at the
negative experiences participants had with lack of accommodations; and occasionally felt
annoyed when participants did not seem invested in the conversation (e.g. taking a personal
call during an interview). These feelings likely stem from my preconceived notions about the
direction of this project, which I frequently had to bracket in order to fully understand the
concerns of each of my participants.

Being the researcher and also being deaf impacted my interviews with participants
who were also d/Deaf, in that I am one of them – even as I am not one of them – a
quandary succinctly stated in Denise Ackermann’s (1998) work when she asks: “How can
one be both the researcher and that which is being researched … we are the same coin” (p.
24). Having the shared experience of deafness allowed me to bypass certain preliminaries in
establishing rapport; there was also a level of basic comfort in discussing the experience of
defauness, even with those participants who had drastically different experiences from myself.
Additionally, when a participant stated she was quitting the government organization where
she worked because they were not accommodating of her hearing loss, my mind immediately
went to my future internship at a consortium with a government component and, feeling
anxious, I was aware of wanting to ask additional questions. I did not always have this same
level of comfort with my blind participants; in fact, in these interviews I wonder if,
subconsciously, I worked harder at establishing a rapport and alliance.
My anxieties also played out in terms of feeling competent during the interview process. When a participant would respond with just a few words, I found myself adding, “if you can” to my next question, as if to let that person off the hook. I felt anxious when participants struggled to answer my question or seemed confused. During moments of anxiety, I frequently turned to a passage in Leslie Broun & Louis Heshusius’ (2004, para. 45) article on reflexivity:

Why am I doing this? Is there anything in this topic that worries or frightens me?
Am I perhaps addressing my own fears? How would I feel in the participant’s situation? What if it were me?

When participants seemed anxious, I felt the need to reassure; when I felt anxious, I wanted reassurance – a co-created cycle that existed outside of my awareness during the interview process. When participants went off on a tangent, I tried not interrupt. I felt compelled to act as the “listening ear” (Ribbens, 1989, p. 56), especially given that the voices of disabled people are not always heard. Yet the structure of the interview required that I sometimes needed to redirect the conversation to the present; it was hard to do this without feeling some anxiety. In these moments, taking a few minutes to remind myself of my goals reduced my level of anxiety as to whether I was doing the interview “correctly.” Taking on the dual role as both researcher and participant was also challenging in that it forced me to confront my own avoidance around my identity as a person with a disability. That I waited so long to code my interviews (and to write my autoethnography) – due to internship interviews as well as a long period of depression – inevitably impacts what I chose to code and why.

**Connection with participants.** Within the here-and-now of the interview dynamics, I felt most connected in those interviews that occurred face-to-face and during affective moments in the interview process. Acknowledgement of shared experiences also
added to the depth of the interview. For example, I bring in more of myself in my interviews with Sophia and Jaime than with other participants; this likely the result of feeling a strong affinity to these women’s experiences. Being able to let go of the script and really enter Sophia’s experiences created a smooth interview flow, as seen below when we discussed shared experiences of using internal felt reactions:

S: As I shared with you earlier, when patients are agitated, for me I feel there's something. I feel like kind of the core of the agitation. So I'm not looking at the behavior.

I: You feel it in yourself?

S: Yeah. And so sometimes I believe that might help me understand. And then that might be naivety?

I: I think what you said makes a lot of sense. If the feeling you have is agitation, not with the person per se, but the sense of it in the self. That’s important. I think that’s kind of what you’re saying. Maybe trusting in that process of how you make sense of other people’s reactions.

S: Yeah. Yes.

Another moment of connection occurred with Octavia when she commented on the experience of being with me:

So for example, you coming in here with me, you brought yourself into the room so you’re allowing yourself to really engage in this exchange […] Sometimes we come into the process and we’re so caught up in – I don’t know – we don’t allow ourselves to be the instrument that the process can work through. (O14.1)

I also felt aware of wanting to be friends with participants, or at least connected to them on a mentee/mentor level. Looking back, it is clear that I wanted to share more of
myself in interviews, something I was not consciously aware of until I re-read my interviews in the coding stage and saw instances where I began talking a lot, especially in those interviews where participants asked me about my experiences of deafness. While some participants wanted to know more about me, others were less interested. Perhaps they refrained from inquiring not out of disinterest but from respect or because they had their own understanding of how to act as an interviewee. Studies show that difficulty in self-disclosing experiences, even with a group of people with whom the researcher shares the same otherness, is not uncommon. Claire Tregaskis & Dan Goodley (2004), qualitative researchers in the field of disability, speak about their experiences:

We find it intriguing that so many disabled researchers we know have not explicitly drawn upon their own personal biographies in developing their research agendas—biographies, by the way, that non-disabled researchers spend many a year trying to authentically access through disability research. (p. 367-368)

While many interviews felt strong, others felt lacking or unfinished. In my reflexive journal, I tried to track such struggles. They seemed to occur in the following situations: when I overly reassured participants; when interruptions occurred; when participants wanted to control the interview; when participants referred to their published writing; when participants seemed to distance themselves from negative experiences by reassuring me; and, finally, when participants deflected the questions. In my first two interviews (Brenda and Bella) I had difficulty bracketing myself from therapy mode – that is, I may have encouraged a particular line of question or over-empathized with participants rather than creating more space for them to talk, all of which subtly impacted our alliance. I remedied my approach in later interviews, finding a balance between staying with my questions and following the participant’s trail of thought.
Additionally, that I asked only some participants to do a member check highlights my power as a researcher: I decided which interviews were strong rather than asking participants what they thought. In retrospect, I could have sent more member check letters, but given the weakness of some interviews (largely due to setup and tech difficulties) I did not always feel comfortable that my analyses were complete, and my anxiety certainly played a part in my decision not to reach out to all participants.

**Presentation of results.** My decision to write a general results section rather than individualized results meant that not all participants got equal representation, that some depth got lost throughout the process, that some statements may have (accidentally) gotten taken out of context, and that experiences unique to the deaf versus the blind were not always teased apart. However, due to the large number of interview participants, condensing themes made the most sense, especially given that this is a new area of research. From the beginning, I have wanted this dissertation to be a starting point in educating others about the challenges as well as the joys of being a therapist with a sensory impairment. Providing the results in the structured format that I did will hopefully make it easier for readers to identify key themes that deaf and blind participants share.

**Deciding not to give payment for participation in study.** One participant who declined participation after reading my consent form asked me why I was not paying for her time. With what seemed like an accusatory tone, she informed me that she had paid her dissertation participants. I replied by saying that I wanted people to participate on their own account, out of a belief that the topic was important and that they had something of value to contribute. I argued that the action that could come out of this project (e.g., community-building, educating others) could not be attached to a monetary value. I also added that I was a graduate student and did not have institutional funding to pay. Thus, my choice not to
compensate was both a practical and principled decision. I am not alone in my impressions; the research on reciprocity argues that most feminist, action-research, and disability studies research does not often pay in the form of money (Price, 2013). I hope the art of my dissertation – as well as my autoethnography, a glimpse of my own experiences – is a gift in itself.

6.3 Implicit Themes: The Here-and-Now of Interviews

Throughout the coding process and in keeping the reflexivity journal, I made note of implicit themes that emerged from the data, with a focus on the here-and-now dynamic of the interviews. These examples fit together in that they highlight the anxiety (as well as excitement) that naturally arises when people with impairments get together to talk about disability. This anxiety, I think, stems from internalized messages about disability from society as well as the vulnerable process of being interviewed.

Participant desire to help or educate interviewer. A common theme that emerged in interviews was the participant’s desire to help me with my project or to ensure they answered questions correctly. At a few points in our interview, Nadine mentioned she knew of other blind therapists that I could reach out to for my study. Grace fretted over whether she had adequately answered my questions since she spent most of the interview talking about accommodations rather than client reactions.

When participants located similarities between themselves and me, they seemed more likely to want to help, as seen in my interview with Brenda: “When I was young I was very brave like you, but now too tired to advocate or to speak up in a new hearing place. […] Interesting report you are doing but I can relate to what you must be going through now” (BR6.1). In reminiscing about her own experiences, Brenda projects onto me her
impressions: that I am brave and we have shared experiences. While there are some similarities between us, there are also many differences: unlike Brenda, I was not in a program that had other deaf students and I am not part of Deaf Culture. Anna wanted me to “not feel bad” for not always hearing the lyrics to a song, as she could relate to that experience (A4.2).

Anxiety and ambiguity within the interview. An analysis of the non-verbal interactions showed that many participants laughed throughout the interview while others tried to control the direction of the interview or replied with short, one-word answers. These moments, which I often did not pick up while doing the interview, point to possible anxiety or ambiguity around either doing the interview or something that the interviewee was remembering or experiencing in the moment.

In some interviews, laughter was shared between us or occurred when the participant told a funny joke. For example, Anna and I laughed after she mentioned a fantasy of a client with a thick accent magically finding another therapist. In other cases, participant laughter appeared to serve as a defense against remembrance of painful feelings or anxiety. When Alex talked about being denied services from the local blind rehab organization, he laughed: “Well, the first couple years I was there they said they couldn’t do anything for me. They said they wouldn’t help me (laughing) because I had gotten an undergraduate degree or whatever” (MU 1.3). He also laughed when telling a story about a time he got hit by a car: “I’ve heard people yell out the window also at me that he’s not really blind, he’s faking it. You know, I’ve had people laugh at me, people honk the horn at me. Yell at me. (Laugh)” (MU 4.2).

Twice in the interview Octavia referenced her mother’s beliefs about blindness and then later said: “Most people think of blindness as the worst thing that could ever happen to
anyone (said with a jovial tone)” (O14.4). Additionally, she laughed when telling the story about the woman who said she was not whole: “And I cried and all that —(laughs)” (O14.4). The jovial tone and laughter here, as transcribed by Christy, suggest that these experiences are not being re-lived in the here-and-now of the interview, but remembered and re-told with slight embarrassment. Similarly, Bella laughed after describing moments when she felt rejected by colleagues, clients, or supervisors because of her disability. Jaime laughed when she seemed surprised by her own interactions and responses. Participants also laughed when they seemed uncertain about their response or even uncertain about my question.

**Desire to control or minimize negative experiences.** Some participants responded to anxiety or uncertainty by trying to control the interview or by minimizing negative experiences. Instead of talking about her own inner experiences, Nadine talked about the students in her multicultural group who were marginalized in other ways (e.g., race). Rather than exploring what it was like for her in graduate school, she simply stated, “it was not an easy time” (N6). And rather than exploring the visible and invisible impact of being told she wasn’t “perfect” by a patient, she stated, “well, you know, it was okay” (N6.2).

Being aware that an interview of this nature evokes vulnerabilities, I noticed that it seemed important to Nadine that she remain in control. Open-ended questions seemed to challenge Nadine’s sense of control; she seemed to prefer questions that were yes or no, as seen in the following excerpt:

I:  A non-describable sense?


I:  Do you sometimes check in with the client?

N:  Oh, yes. Oh, yeah. And that's also a good practice for anyone, yes.

I:  So that's one way to kind of establish –
N: Rapport […] Yeah. Yeah!” (N12.7)

At other points in the interview she seemed overwhelmed; to my question about problem-solving, she said, “Oh, my goodness, there are so many…” (N12.6).

As I think back to this moment in our interview I wonder if Nadine felt in some way threatened by my questions, as if I was looking for her to provide a specific kind of example. It also seemed that when she did not fully understand something, she shut down by saying “yeah” or returned to a familiar topic. She did not tap into emotional states. Instead, she said, “It’s okay” or “it happens.” Indeed, she “separate[d] herself” as an “object.” As stated before, I wondered whether the act of separating herself as an “object” functioned as a kind of defense that she had developed over time in order to protect herself from overt oppression or prejudice and in order to have others see her as competent.

Octavia also seemed to avoid difficult feelings at times. When talking about her hyper-compliant client, Octavia says: “And for me I was angry about my blind – I felt it within myself” (MU 20.4). She doesn’t finish the first part of her sentence but shifts gears, which might suggest possible anxiety around speaking.

Again, my analyses here are based on implicit themes and may not accurately reflect what participants were thinking as they shared their experiences; it is important to bear in mind that interviews lasted 55-90 minutes, hardly enough time to build a rapport where one might feel safe to disclose more uncomfortable feelings.

6.4 Conclusion

While I had many opportunities to write this past year, I often felt reluctant about this project, worrying that I had misrepresented my participants, worrying that my questions were off base, and so forth, worries that I now see as habitual responses, stemming from
ableist views about what constituted good research. In acknowledging how my own access
needs and those of my participants were sometimes compromised by my belief that I had to
conduct the interviews exactly as described in Smith, Flowers, and Larkin’s (2009) IPA book,
I was able to see how my project was impacted by my own unconscious ableist assumptions.
By integrating a disability studies framework into nearly every chapter of this dissertation, I
attempt to complicate ideas about how research should be conducted, especially when
working with marginalized populations.

As I come to the end of writing this dissertation, I am aware that my reflexive
analyses are partial, ongoing, and will likely change as I continue to discuss this project. I also
imagine after taking some space from the dissertation and then returning to re-read the
interviews, new and important thoughts will arise. My ever-changing relationship to the work
at hand seems fitting in that the lived experience of disability is also fluid and open to
questioning. I continue to share my reflexive thoughts in the next chapter, the
autoethnography.
Chapter 7
Autoethnography

*The lived experience of disability reminds us that we are not in control of our messy, disordered human bodies.*

*As a lived experience, disability is profoundly ordinary because we all experience or will experience some level of disability over the course of our lives.*

--Lennard J. Davis, *Enforcing Normalcy*

7.1 Introduction

From the earliest conception of this dissertation, I have thought about how I might provide readers with a collaborative witnessing of the phenomenon of disability as it plays out in the therapy; problematize assumptions often held by nondisabled therapists, as well as my own beliefs; and incorporate relevant aspects of myself into my research while keeping the focus on participant stories. Much of my development as a therapist has stemmed from challenging societal norms about disability, though I did not come to this path until a few years ago, having spent most of my life perceiving my deafness as an impairment that I could “overcome,” a belief that I now understand as neither positive nor negative but simply shaped by the sociocultural and class environment in which I grew up.

As addressed in the literature review, the use of autoethnography can problematize the role of the researcher when the researcher is explicitly located in a narrative and therefore cannot be understood as absent or neutral (Hertz, 2006). Researchers who utilize autoethnography aim to provide “complex, insider accounts of sense-making and show how and why particular experiences are challenging, important, and/or transformative” (Adams, Jones, & Ellis, 2015, p. 27). Researchers intentionally use personal experience to create nuanced, complex, and comprehensive accounts of cultural norms, experiences, and
practices that facilitate a collective understanding and encourage the mainstream population to think about taken-for-granted norms and experiences.

As I was in the thick of this dissertation, certain life and professional events came up that seemed coincidental given the topic of my work. At my fifth-year externship, I worked with a Deaf client who communicated only in ASL and who, out of fear of abandonment, was quick to judge my own ASL skills. I saw an audiologically deaf therapist, new in her training, who irritatingly reminded me of myself. I spoke up about microaggressions occurring on an internship rotation. Such experiences influenced the writing of this dissertation and pushed me toward acceptance and ongoing exploration of disability.

Working with my Deaf client, I felt discouraged that my ASL skills were not up to par and regretted that I had not maintained my signing skills growing up. I found myself longing to feel more connected to a Deaf community, something I hope to seek out following internship. My experience with the deaf therapist, although short-lived because I moved away, gave me an insider look into how patients experience me, repetitions and all. Watching her speak was painful – and I often found myself wondering, did my mouth look like that? Then I would immediately feel bad for having that thought, becoming aware that I needed to work through my own prejudice. Additionally, in grappling with my initial annoyance at feeling like she could not hear me, I was forced to confront the times when I was the recipient of such feelings by my patients, forced to confront the times I did not hear every single word they said but felt too exhausted from lipreading all day to ask for repetition. These experiences, while difficult and depressing at times, were also eye opening and empowering; that they dovetailed with the inception of this dissertation also feels poignant.

This chapter is not a formal autoethnography; rather, it offers parts of an incomplete whole, bits and pieces of my life that seem relevant to the topic at hand. The disjointed,
poetic, and weightless form in which I write mirrors my being in the world, where language is often a blurry mystery of undistinguishable sounds that linger in the air, waiting to be taken up, made accessible. I touch upon aspects of my experiences as they converge and differ from those of my participants, which is important to note given that we do not share the same experiences of disability and that we all hold different types of privilege; for example, I do not worry about others questioning my race or citizenship. Throughout this chapter, I also question how my experiences and those of my participants crip larger societal norms and expectations about disability. It is my hope that this partial autoethnography, still a work in progress, complements and expands upon other ideas and themes addressed in this dissertation.

7.2 A Partial Autoethnography

As Sophia talked about the experience of pretending she understood conversations that were inaccessible, I was reminded of having made similar choices. She stated: “I would never tell anyone that I couldn't hear if I could avoid it. I would avoid it” (S1.2). I, too, have avoided asking people to repeat, often because I felt it was an imposition, especially outside of my immediate family.

My parents learned that I was deaf when I was just over a year old. This was 1982 and Deaf Culture had not yet gained attention in mainstream media as a positive source of community or support. Schools for the Deaf, of which most states had one, were often seen as a last resort, where the kids who couldn’t speak (and were thus falsely perceived as having low intelligence) often attended. Much like Sophia’s early experience (S1.5), my parents wanted to emphasize my cognitive abilities and strengths, and so with the support of a sign
language interpreter, I attended school with hearing kids. I participated in clubs and sports and had a few friends, though I didn’t feel particularly close to anyone. My childhood was mostly spent roaming outdoors with my younger brother or, as was most often the case, reading a book or writing in a journal.

Very early on it became easy to pretend that my disability did not exist, even with the sign language interpreter at the front of the room. At a young age, I learned how to “perform hearing” and to fit in. I learned appropriate responses to certain situational cues without always knowing the content of what was happening. I attended movies without subtitles (and laughed and cried in all the right places), sat the back of the classroom where the popular kids sat, and quickly learned that “yes” was the answer to most things. I went to the movies because I wanted to be with my friends, to not feel left out, to get coffee after in Old Town, Eureka. Watching movies, I never quite knew what was going on in terms of the content, but I could sense how the characters were feeling through non-verbal exchanges, through my own internal reactions – and sometimes that was enough for me. I also learned that it was easier to tell people I couldn’t hear anything at all, so they would look at me when speaking, rather than the reality, which was that I could hear a lot of sounds but not make sense of them (unless the person was looking at me). My experience of sensorineural deafness is not unlike Octavia’s experience of cortical blindness, where her “functioning eyes” know where to look but her brain does not interpret what she sees (O14.7). Being part

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I should note that I grew up with Signing Exact English (SEE) and not the nationally and culturally recognized American Sign Language (ASL), which I learned in college. SEE is a system that uses English grammar and signs the words as they would be spoken; ASL has its own grammatical structure that is very different from spoken English.
of a hearing family, with loving and supportive parents who wanted me to fit in and be happy, made it easier for me to learn the appropriate cues. I performed so well that I was not even aware of performing; it felt natural to me.

I knew other deaf children growing up, and was friends with a few of them, but most of them spoke only in sign language whereas I used a combination of speech and sign, often awkwardly. Throughout most of my elementary years I attended speech therapy before school, and after school I would board the little yellow bus that was for special needs kids for my ride home. At the time I didn’t mind much, as it was something to do and having things to do kept me from feeling anxious, though I did feel out of place and often sat in the back, reading. I had few, if any, adult role models of people embracing disability, and I had no language for understanding alternative modes of being.

In high school I coped with not understanding group conversations by moving around from group to group at lunch, never spending too much time with any one because it was always harder to understand fast-paced conversations after the pleasantries; my friends would say hello, ask after me, and then whisper something to another friend. I would stay for as long as I could tolerate, then leave for the library. It didn’t really occur to me to ask people to repeat themselves more than once, if at all.

During those tumultuous years of adolescence, where simply existing in the world felt so wrong, I would often walk to the bus stop cataloging all the ways I was different and therefore deficient: I liked girls, I was chubby, I was deaf, and I wore big glasses. My sophomore year in high school I toyed with the idea of transferring to the California School for the Deaf a few hours south of home. I was feeling left out and I wanted to fit in, to get all the conversation, to not have to pretend. Yet, when I visited as a prospective student I was denied entry to the school’s classes because I was “too advanced” and would have to
take classes at the public school down the street. But I was welcome to board with the Deaf students. I remember thinking, what a joke – mainstreamed again?

It was not until I started to question my sexuality, around the age of 15, that I began acknowledging the ways my hearing loss separated me from others. Yet embracing my gay identity, however complicated, was easier than embracing my deaf identity, from which I frequently hid. I knew one or two successful gay people and there was a shelf for LGBT-themed books at the local independent bookstore; there was no such shelf for Deaf Studies. Then, and sometimes even now, locating myself as disabled felt scarier, more uncertain, more tenuous, than locating myself as queer. Unlike with my hearing loss, which is so ambiguous and mysterious (I may hear you one minute but not the next), my sexuality feels concrete in that it connects me to a community. If anything, my gender presentation (as genderqueer) feels more like my experience of hearing in that it, too, is fluid and ambiguous.

Attending an all-women’s college, where the focus was on self-growth, feminism, and intellectual activity, made it easier for me to seek out friends who were accepting and accommodating. But even then, because I had not done the work of self-acceptance, I did not ask much of them, or myself. I continued to perform hearing, often unconsciously, though it felt easier to perform among women who were accepting of other parts of me (e.g. my sexuality). At various points during college, I attempted to integrate into Deaf Culture, but never quite fit in because I preferred speech to sign. In this way, I always seemed to straddle two worlds. I made my world between worlds, between identities, between cultures. And I often wondered, as Deaf scholar Irene Leigh (2009) did, “Is it denial to acknowledge ‘deaf’ and not embrace it?” (pg. 28).

My junior year of college I decided, on a whim, which was how I did most things then, to study abroad at St Andrews University in Scotland. I still remember my father
driving me to the airport and speaking with concern about whether I would be able to understand the Scots. Quite frankly, it had not occurred to me to think about that, even though I was attending a university with high proportion of international students. I simply didn’t surround myself with those I could not understand. I remember arguing with him out of anxiety, saying I would be fine. That semester was difficult and depressing in terms of making friends, but it was also the time I was introduced to formative writers that would later influence my decision to seek my first graduate degree. Writing this, I am reminded of something I wrote during that time, that I think captures a phenomenological portrait of my experiences.

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My curious bond with Rob began one blustery St. Andrews autumn over Bailey’s ice cream and sweet potato fries, our favorite midnight snacks after too many pints at the pub. Rob was Scottish, straight, hearing, and charming. I was American, lesbian, deaf, and sarcastic, far away from the comforts of home, a place where I could interchange “passing” for the more authentic experience of being deaf (and lesbian). My inability to lip-read the Scots encouraged me to pass as hearing (or simply mute in cases when I was tired of passing), and thereby it seemed most natural to “try” being straight. By “passing as hearing” I simply mean either pretending to understand the conversation or actually understanding the conversation but not admitting that I was reading lips. I was 21, both in love and disenchanted with myself and the world. Enter Rob with his long curly brown hair, tea-stained red wool coat, and love for ancient poetry. His Scottish accent changed the shape of his mouth so that lipreading became nearly impossible. So, our relationship became one of comfortable silences, awkward touching, book-swapping, and many hours making out. Rob’s lips were pleasantly warm and kissing him gave me control over my life. Touch was a language I knew well, even if the subtext was different. Touch was a language I could capitalize on, exploit for my own desires. But of course,
our authentic selves have a way of reminding us that “passing” is simply an exhaustive performance and I couldn’t keep it up for long.

I did not just pretend with Rob, but also in class. The choice to pretend I followed the discussion in my creative writing workshop was, in part, because there was nothing the professor could do about his accent and, in part, because the disability services could only provide me with a British Sign Language interpreter. Not being fluent in issues related to Deaf Culture I wasn’t aware, at the time, of the major differences between British and American Sign Language, differences too big to overcome. So, I sat at the back of the class and happily read and wrote in my journal, wrote without a critical eye looking over my shoulder, which is how one must learn, or relearn, to write. Given that most of my world, at St. Andrews and elsewhere, is colored by silence, perhaps it’s no surprise that I came into writing – a writer needs solitude and I certainly had that.

With all its trappings for miscommunication and melancholy, with all its drunkards on the streets late at night who shouted indistinguishable catcalls, with the boy who kept me from being lonely, Scotland became a faded photograph that I had a hard time locating, a study-abroad fact shared at uninteresting parties when the conversation stalled. But eight years later Rob still appears in all things red wool, in the first taste of Bailey’s Irish Cream, in too-neat cursive handwriting, in guilt when someone holds my hand and I look away, wishing for something else.

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Following college, I pursued an MFA in creative nonfiction writing. In the hot desert of Tucson I began to write about my experience of hearing (or not-hearing); about sounds just outside of my reach; about deep isolation; about the intersection of queer and deaf identities. Yet, even then, my writing was unconsciously geared toward making hearing
people feel comfortable about my experiences. Only when I changed fields to psychology and began my PhD program did I start to feel irritated and angry at not being able to hear, and for the first time in my life I was amazed that I had spent so many years passing by choice and necessity. Like racial, gender, and queer passing, the option of passing as hearing provided me with a sense of privilege, in that others forgot I was deaf. But passing also created a profound sense of internal dissonance and unhappiness. Trying to pass as hearing further disabled me.

In my early thirties I began to confront the tensions inherent in my identity of being a person with a disability, focusing less on overcoming and more on charting my own path. As a therapist I am also shaped by the many hours I spent in therapy during my graduate years, when I was not in class, teaching, or seeing patients. In addition to the short time I spent with the deaf therapist, my year with KK and nearly two years with RH, before his untimely death, were always sojourns in a busy day, spaces where I could explore resistance to my deaf identity, begin to accept that my experience will always be one of interruption and half-heard sounds but that interruption does not always equate with loss. I remember, in our second or third session, KK telling me that I should always ask him to repeat if I didn’t understand him. I appreciated the gesture (and probably laughed at the time) but even then it was difficult. During these years, I also came to understand why I so often sought out relationships or close one to one friendships – unconsciously, I always seemed to be looking for that someone who would fill what felt like an existential hole within me, who would not just hear for me but with whom language would always be accessible, visible on the lips or the body. For years, I looked outward rather than inward before realizing that inward was the only place to look if I wanted to fulfill the emptiness that I had carried for so long.

My relationship with my visible and invisible identities remains ambivalent; it is in
this ambivalence that I’m able to help my patients cultivate a relationship with their own marked and unmarked identities. There are patients who challenge me, who don’t believe I am deaf because I appear to understand them, for instance, when walking down the hallway to the session room. If they are talking behind me, I often say “mmm.” It is not that I’m ignoring them (as I have told these patients multiple times that I cannot understand them when they aren’t looking at me); rather I’m trying to maintain the therapeutic frame by not engaging in small talk before the session. In our interview, Octavia described a similar feeling of being challenged:

[The patients will say], “No Dr. C-- , you’re not blind, you’re probably faking it” – those kinds of things. […] “Is she really blind? She keeps saying she’s blind. She walks with that cane. But I’m not sure. […]” There’s a very fine line because, kind of, what really is happening in the room and how I respond to it. (O12.8)

In this excerpt, Octavia is speaking about how she chose not to reveal as much about her disability in a group setting because she wanted to keep the focus on the members and the processes happening in the here-and-now. In making this clinical decision, she made a trade off: she could control what she revealed, as a means of feeling comfortable, but not how others interpreted her. Such decisions about how much and when to self-disclose, how much and when to pass as sighted or hearing, happen on a daily basis for most of my participants, including myself. And, as Alex points out, after sharing a story of being accused by passersby that he was “faking it” while crossing the street without a cane, it can be hard for my patients to understand that the experience of disability is not “all or nothing” but a “continuum” (AL1.4). Donna also described a similar experience: “When I go out into hearing populations, I tend to get two reactions: sympathy/overkill in trying to address my needs [or] doing nothing because I appear ‘hearing’” (D4.6). Reading these excerpts again, it
is important to note the difference between appearing as sighted or hearing and actively choosing to pass (although they can overlap). The first represents how one is perceived, often from a distance, and the latter represents an action on the part of the person with the disability, even if the person is not actively aware that she is trying to pass.

Returning to my own experiences, missing out is still incredibly difficult but I no longer experience it as a loss that is suffered, like the moment when someone points and you turn but not in time, or like someone’s hand you cannot quite reach no matter how hard you try. Rather, it’s an invitation of some kind, including an invitation to get to know myself further and to set boundaries with others about what I will and will not do, especially with regards to groups. Acknowledging my frustrations and limitations has helped me to begin creating a life where what matters to me is actually accessible, such as one-on-one therapy. The stress of doing groups, even with accommodations, is not always worth my energy, so now I am selective about the size of the groups that I facilitate.

In regards to how deafness has impacted my therapy work, I could relate to many of the themes my participants discussed. Similar to Sophia, if I get a patient I cannot lipread and for whom there is trauma, I will transfer that person out for safety reasons. However, if I get a patient that I cannot lipread but where I sense that the content of the patient’s words matters less than the therapeutic dynamic between us, I will keep that person. For example, two years ago I had a client who was impossible to lipread. Her big teeth and perpetual wide smile did not help. But she also talked at lightning speed and no matter how many times I asked, she could not slow down. Her fast speed was symptomatic of her underlying issues – it prevented her from truly listening to her own experiences. I heard enough to know that many of her stories were about other people – about this friend or that friend – rather than herself.
After a few weeks of struggling really hard to understand this patient, purely on the audiological level, I realized I had to let go of “hearing” her if I was going to understand her on a relational, therapeutic level. I had to wait for the real material to appear. I listened as best I could, made appropriate therapeutic remarks, and began asking more direct questions about how these stories impacted her. What did her brother’s breakup tell me about her? What did it mean to her that her two friends had a fight? By turning the focus on her, this client was forced to look inward as well as to notice me, perhaps for the first time. Reflection was challenging for her and she was often at loss for what to say. But she was speaking more slowly and this made it easier for me to pay attention to underlying psychodynamic themes. Shortly after, this client commented that she had not realized how much I was missing until that point. From then on she was more conscious about speaking slowly and, in turn, I felt less driven to pretend I understood her. There was no need any more; the work had been done.

Not all of my experiences have been successful. Sometimes keeping on a patient that I cannot fully understand backfires. At that same university, I had three sessions with a patient who presented with antisocial and autistic qualities. He mumbled, spoke unclearly, and I was always asking him to repeat. At the end of our second session, where he spent most of the hour in silence or mumbling a few words about an obscure video game, he said he had something important to share. He spoke and when I misheard him, his eyes turned dark and cold. He said it again: “I like watching videos of rape.” I remember feeling nervous and a bit scared. I mirrored his statement, asked him to say more. I tried to speak softly and openly. But was quiet and refused to repeat. He didn’t return after that session. Perhaps he needed me to challenge his statement. Perhaps it was too much for him to repeat or to hear his statement mirrored. Perhaps his refusal to return had less to do with my hearing and more to
do with his psychological state. Regardless, this experience highlights how some patients simply cannot or do not have what it takes to make accommodations or even to accommodate the therapy space such that a relational experience can occur.

While interviewing participants, I sometimes felt the urge to share aspects of my experience, hoping they might have similar experiences. One such experience was that of the exhaustion I felt lipreading day in and out – an act that is as unconscious to me as is walking or breathing. In fact, I only really felt this exhaustion after a full day of graduate courses and therapy where I had to train my gaze on those speaking. I remember when I told Jaime about my experiences with this, I initially felt a little anxious, as if I might be alone in this experience, but she was quick to agree, stating that with lipreading, we “do so much just to get to the starting line” (J6).

In recent years, I’ve come to view passing as a multilayered and complex experience, often a personal choice and sometimes a necessary act of survival. When society focuses on the disabled person overcoming, achieving, being given access to the same things (without awareness that the thing itself is experienced differently by each person), and creating equality, there is less space for acknowledgment of the fact that the very world upon which these notions are built is inherently flawed and unequal. I pass when I need to take a break from the exhaustion of lipreading and regroup; I pass when I do not feel safe speaking up and need to protect (and respect) myself. Passing is not about trying to make normative structures work for me but about finding ways to upend such structures and to challenge the lack of universal accessibility in our society. When passing becomes something I own, something I bend to fit my own needs, it feels like less of a betrayal to those who cannot pass and more of a necessity to survive in a largely inaccessible world.

In sum, training as a therapist has made passing both harder and easier — harder in that
I no longer wish to pretend that I can understand the Other, easier in that a lifetime of passing has sharpened my non-verbal skills such that even when I do miss something, I have other ways of understanding the conversation. That there are multiple ways to understand spoken conversations suggests that a future where universal accessibility as the norm might actually be possible.

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Rather than highlighting the differences among (and within) the abled and disabled, universal accessibility argues for the “the design of products and environments to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design” (Vanderhooft, 2013, p. 48-49). Universal design moves beyond private conversations about individualized accommodations to public conversations about needs for all. Moreover, universal design, or access, often goes beyond the traditional narrative of visible/invisible disability to include other forms of difference, including class background. In other words, one narrative, or one accommodation, does not fit all.

Navigating accommodation difficulties was one of the biggest challenges for many participants, especially in terms of internship and jobs. Donna quit her postdoc because of lack of accommodations. Alex did not have sufficient funds to make his job easier at the UCC. Octavia wrote her notes in MS Word and sent them to someone else to upload into the Electronic Records System. Grace did not have access to transcripts of her therapy sessions. I have been denied the chance to work with certain groups because my then supervisor feared that remote transcription would “activate” the psychosis of patients with schizophrenia. Luckily, I had few hardships getting accommodations at Duquesne, which I attribute to the largely progressive faculty that make up the clinical psychology department.
and, more importantly, to their willingness to listen and learn about alternative forms of access. Not all places have been as open and accepting as my home institution. Internship, while a wonderful training experience in many respects, has proven difficult with regard not just to accommodations but also because of ignorance on the part of some staff at one of the three institutions where I rotated. Through a difficult few months, where my supervisor frequently spoke about being “anxious” about having a deaf intern, I often thought of Donna, the deaf participant who left her postdoc because they did not accommodate her needs.

One rotation of my internship was a struggle all around, especially in terms of the daily microaggressions that occurred in team meetings. When I attempted to respectfully point out that I had a really hard time hearing in that space because people were constantly talking over each other or taking calls, my supervisor replied by saying, “Well everyone has a hard time hearing.” I tried to explain, very openly, why that was a problematic statement. But she had stopped listening by that point, instead focusing on other things she felt I was not doing well on the unit. Later, it became apparent that she feared a discrimination lawsuit and went to her supervisor. The three of us had a meeting where I ended up being apologetic and catering to their needs, out of my own fear that I would be asked to leave.

This small example demonstrates how when people with disabilities attempt to call out microaggressions and break down problematic structures, new walls get built – walls that often times only the person with the disability can see, touch, come up against. To quote from Sara Ahmed’s (2015) keynote speech at the National Women’s Studies Association Conference, “To those who do not come up against the wall, the wall does not appear.” Those in power are not invested in seeing the walls that they put up or sustain. In doing the
work of drawing attention to microaggressions and ableism at my internship, I am seen as the one creating the problem; in fact, according to Ahmed, “I have become the problem.”

In this rotation, I could also relate to Grace’s experience of the therapy space as being a refuge from outside oppressions. As all this was happening, I dove into my clinical work with the few patients I was allowed to treat and attempted to create meaning within these relationships, so that I could at least finish the rotation on a somewhat positive note. While this was happening in one building, across town in another building I was in supervision with a psychoanalyst who is blind, and who understood the experience of daily oppression while also being aware that her hands were institutionally tied, so to speak, in terms of helping me. The experience of working with someone who also has a sensory disability, albeit the very sense that I rely most on, is a comforting and strange experience. She and I have many in-depth conversations about our shared experiences of oppression and about my clinical work. Yet there are also times when I feel anxious that she’s not giving me the usual facial expressions I so often rely on; in fact, I did not realize how much I relied on the “normative social practice of eye contact” (Kleege, 1991). She also has a hard time hearing, so I must sit close to her and work hard to speak clearly. In this dynamic, accessibility becomes co-created as we both work to meet the other’s needs while still having productive clinical conversations. Like many of my participants’ patients, in not being “seen” visually I feel more comfortable speaking what is on my mind. I fear less judgment.

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The therapy space is different from outside spaces in that it calls attention to co-created dynamics between the therapist and patient, including patients’ assumptions about
ableism. Yet therapists make assumptions too. At one of my counseling center externships I worked with a culturally Deaf client who presented with severe trauma, abuse, and characterological struggles. “Mark” was a junior and had transferred from multiple universities, in search of the perfect place. He also communicated only in ASL. He had no Deaf friends because he felt like those in Deaf Culture were “not very smart” and also “too blunt.” But he had also no hearing friends on campus; he felt like his classmates were only interested in him to learn sign so he shunned them before they could even say hello. Professors were “always” discriminating against him and accommodations were never “good enough.” Mark was assigned to me, even though I am not fluent in ASL (proficient at best). After ten minutes of conversation, he immediately requested an interpreter because my signing was not “good enough.” He then spent the rest of that first session finding subtle ways to let me know I was inefficient. Initially, I liked Mark but quickly felt annoyed with his continual jabs, even after an interpreter was incorporated into our therapy. Mark knew my weaknesses and seemed to know that I felt some embarrassment at not being fluent in ASL or part of Deaf Culture. I frequently wished that Mark would see a culturally Deaf therapist in the city. I assumed he would do better working someone who understood his struggles. But he refused, asking, “How do you know what’s best for me?” I didn’t. This wish was my own – perhaps even one that I had for myself growing up. Understanding Mark’s behaviors in light of his childhood trauma and abandonment from parental caregivers helped me to not take his criticisms personally. With Mark, therapy did not become a refuge from outside oppression as much as it served to highlight my own biases about what was best for my culturally Deaf patient.

Another example of how microaggressions play out stems from my work with a black supervisor where we both tried to articulate a marginalized experience only to
experience the other person as “doing microaggressions.” When this happened it was harder for both of us to step out of our own framework and to understand the other person’s perspective. For example, this particular supervisor insisted that I should be able to “overcome” my difficulty hearing some of my patients because she herself was constantly working to “overcome racism” to fit into the workplace. Rather than being allowed to assert my own boundaries, I was told to “find a way.” As a person of color, she said, she did not have the luxury to “give up.” This experience was really eye opening for me in terms of exploring how my white privilege gave me power in the supervisee-supervisor relationship. It also taught me about how quickly disability gets conflated with other marginalized identities, rather than seeing it as a different kind of oppression that merits a different kind of response. When marginalization is not just about power but also about embodied difference, the social model of disability comes into question.

Many participants also described feeling dismissed when they tried to start a conversation with supervisors about the differences in the room. As Grace spoke about her frustration around supervisors not trying to understand her experience, I was reminded of a supervisor I worked with who, in his anxiety that I might lose a patient, forced me to self-disclose my deafness earlier than I felt comfortable. This supervisor was supportive in terms of case formulation and theory, but not as supportive in terms of failures and mistakes. I found it tricky to navigate the issue of what to present in supervision, as he seemed most interested in questions or topics related to certain aspects of the therapist-patient relationship and while that was important to me some of the time, I had other concerns.

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The stories in this dissertation illustrate a phenomenological representation of disability that has not yet come to the forefront on the literature of psychotherapy and disability studies: a phenomenological psychology of disability. As an embodied model, a phenomenological psychology of disability creates space in the phenomenological discourse for the disabled person’s experience, not as a new norm but as a felt experience of difference. It challenges conservative ableist thinking: just because one accommodation need is met does not mean that others do not exist or even that the accommodation itself is perfect. A phenomenological psychology of disability argues for a new perspective – and even an overhaul – of problematic social norms in a dis-aligned world naturally built to serve the able-bodied. This topic is further discussed in the next chapter.

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I tried to start this autoethnography many times throughout the course of a year, making notes and cutting and pasting from other documents before finally sitting down and acknowledging my own resistance. As stated earlier, my reluctance to write comes not from disinterest but simply a deep exhaustion at my core – from the last six years of graduate school, from performing hearing and resisting ableism, from not performing hearing and speaking up, and so forth. Writing this now, I’m aware that the exhaustion I feel is starting to affect my clinical work. I do need a break, a long one, of some kind if I am to move forward, and in the future I will need to schedule more mini-breaks throughout the day. I also need to recognize that I am extremely driven and motivated to go above and beyond, to keep reaching higher, a drive that stems both from an authentic desire within me to succeed but also a lifelong habit cultivated by a society that believes in overcoming and performing.
Through the process of writing this dissertation, I’ve frequently reflected on the nuggets of wisdom my participants shared with me: about the importance of self-care; about feeling confident in the boundaries I’ve set within my therapy practice; about trusting in my own inner process and that the patients’ words, if important, will come up again. These messages feel like transitional objects that I can carry with me as I navigate the second half of internship and my future career.

In joining in with my participants’ stories, in contextualizing their lived experiences, I amplify the voices of the deaf and the visually impaired. It is my hope that this partial autoethnography contributes to knowledge production within disability studies and psychology while also valuing relational experiences that exist in the here-and-now, as it is in these relational spaces where meaning-making occurs.
Chapter 8

Conclusion & Implications for Future Study

"Disability can be an occasion for suffering, but it can also be an occasion for joy, knowledge, and connection.

Disabled people do not suffer inordinately, but the conditions for human suffering are increased when we do not have access to the resources we need." – Rosemarie Garland-Thompson

8.1 Introduction: Reflection on Study

The results from this dissertation illustrate the lived, phenomenological experience of therapists who present with an auditory or visual impairment and its impact on their clinical and professional life. While participants discussed the struggles they faced in everyday life, more often they discussed the joy they got from practicing as a psychotherapist, the meaning-making that transpires when disability is felt, challenged, and talked about alongside open-minded patients (and colleagues) who want to join in on the accessibility work; that is, to carry out into the world what they have learned from the therapist rather than expecting the therapist to hold the burden of educating.

The plethora of topics that emerged in this dissertation include the unique challenges participants faced in the workplace or graduate school; the relationship between embracing disability and one’s confidence as a therapist; the connection between self-disclosure styles and patient questions about the therapist’s disability; the different ways patients use the therapist’s disability to hide or reveal aspects of themselves; the role of disability in transference and countertransference reactions; the complexities around embodying or rejecting the supercrip narrative; and, finally, the ways in which this project design, interview setup, and analyses both met and fell short of meeting the access needs of the researcher and
those being interviewed. Implicit themes, such as participant reactions to the interview, were also coded and discussed.

In this final chapter, I bring together the different aspects of my study in an effort to develop a theoretical understanding of how my participants’ lived experience of otherness is impacted by prevailing models of disability and sociocultural messages. In this vein, theory becomes a way of understanding the experiences that took place in my participant interviews as well as in my own life. I also discuss the phenomenology of disability and draw attention to the objects and different communication styles that play out in my participants’ worlds. In considering how my results might contribute to conversations happening at the intersection of psychology and disability studies, I hope to bring a new voice to the field. I then conclude with directions for future research and the limitations of this study.

Across interviews, most of my participants implicitly endorsed the sociopolitical model of disability, one that distinguishes between the physical or psychological impairments that people have and the oppression they experience living in a society that often disables them. This theme came up most often in the discussion of the challenges participants faced. Yet, this model suggests that the experience of disability could somehow be “corrected” if society and the environment somehow changed. If the presence of stairs disables someone who uses a wheelchair, the presence of a ramp does not eliminate the disability; that is, the felt experience of the physical condition (such as pain) and the lived experience of wheeling through the world (e.g., having to put pressure onto the wheels to make them move). The aforementioned example, as well as participant experiences, lend support to what the late disability studies scholar Tobin Siebers (2010) called the “embodied intersectional model of disability,” one that “values disability as a form of human variation[,] raises awareness of the effects of disabling environments on people’s lived experience of the body, [and] theorizes
the body and its representations as mutually transformative” (p. 284). As my interviews demonstrate, the experience of blindness or deafness is an experience of the body in that some participants tuned into felt bodily senses to make sense of their patient’s inner experiences in the quiet of the therapy space; for example, when Jake talked about how his patients felt he could “hear their eyes rolling” (MU 27.9).

As discussed in the first chapter, the crip model draws attention to the importance of noticing differences among disabled bodies; it “aims to [destabilize] the category of disability and opens its borders to include more and different kinds of bodily and affective experiences” (Johnson & McRuer, 2014, p. 135). Rather than asking “what is ableing about disability,” as I asked in my dissertation proposal, we need to remove ableism as a starting point, as the norm, and re-imagine and re-construct a world where there is no longer a divide between the disabled and able-bodied, where the goal is not to “overcome” but rather for lived experiences to co-exist and contribute to creating a more socially just world. As Robert McRuer (2006) notes, if the disabled person deconstructs what it means to be normal and abled-bodied, than the disabled person who chooses to pass constructs ability, an idea that I explored in my autoethnography chapter. In choosing to not speak up when I did not hear something, I passed and gave the impression to others that all was well, that there was no need to crip existing structures. Yet, as I discovered when telling a family member for the first time at the age of 31 just how much I was missing and his response was to cry, when one constructs ability it can shut out those who most who want to understand, those who want to participate in the de-construction of ability. And this often begins with a close look at one’s own ableist privilege.

Additionally, the disconnect I felt in some of my interviews in terms of not being able to relate to all of my deaf participants’ experiences suggests that the phenomenology of
disability as it exists in a cultural and social world is different from person to person. Many people with disabilities, such as Nadine and Grace, may feel safer holding onto to the notion that they must continue to strive to overcome, to gain approval. Disability studies scholars would do well to recognize that there is no shame in one’s desire to overcome or even one’s preference to implicitly embody a supercrip narrative. When one lives in a world that is not universally accommodating or understanding, as do my participants, there is a necessary safety in this narrative. From a psychological standpoint, one could even interpret the supercrip narrative as a defense or survival mechanism. The amount of energy it takes to live with a severe auditory or visual impairment leaves less room for one to actively engage in critiquing normative structures and radically re-inventing new structures. For example, there are times throughout my day, my week, when I don’t engage in the act of educating others, pointing out microaggressions, or actively working to upend problematic mainstream beliefs by, say, attending a rally or demonstration. There are times when I do want to “fit in,” to be seen as someone who has “made it despite X.” My capacity to get to a certain point to be able to find safety in the narrative of overcoming – as well as later coming to reject that narrative – points to the class privilege I had growing up in that it gave me access to resources, hearing aids, and education. Not all participants had access to such resources; thinking back to participant interviews, there were moments I wished I had asked participants more about intersecting identities (e.g., race, class, and gender).

Moreover, in considering the psychological implications of such a defense or survival strategy, space opens for psychoanalytic theory to contribute to scholarship in disability studies. Psychoanalytic theory can provide insight into the ways in which sociocultural knowledge impacts conscious and unconscious feelings, decisions, and beliefs that people may hold about themselves. For my participant who withdrew, we can imagine that
something in her psyche felt threatened after she revealed aspects of herself to me; these parts were likely connected to her internal world of self-other objects. But psychoanalysis, like traditional models of disability, also falls short as a stand-alone theory in its tendency toward prescriptive understandings. Thus, as proposed in my introductory chapter, I turn (or re-turn) to the phenomenology of disability as the primary mode of making sense of my participants’ worlds. With its focus on the subjective experience of the person, bringing in theory related to phenomenology might offer the most insight and useful discussion in terms of interpreting participants’ (and my own) lived experiences.

8.2: The Phenomenological Experience of Disability

My interviews demonstrate how the lived experience of sensory impairment is a phenomenological experience, one that is unique for each participant. For example, when the “thing” of Grace’s hearing aid is assimilated with her umwelt, the world of language is called; the aid allows her to speak in an “appropriate” volume and “perform hearing” alongside her patient. Yet, in choosing to conduct a session without hearing aids, she challenges the notion that she needs the “thing” of the hearing aid in order to do her job. Instead of adapting, she asks the patient to adapt. Instead of striving (and thus exhausting herself), she steps back and informs the patient of the change; she does this because she trusts her own clinical judgment. The experience of having a different kind of therapy session will have meaning for both of them. The lived experience is not just Grace’s but also her patient’s, therefore turning her disability from a negative perceptual difference into a revolutionary moment that hopefully the patient carries with them after they leave the session.

The lived experience of language also challenges normative ideas about
communication between the disabled and nondisabled. For example, some able-bodied persons prefer to interact with the disabled only when the other’s disability is concealed (Samuels, 2013), or when conversation is focused on themes of redemption, such as in the instances when one “overcomes” a disability and/or adapts to the norm (e.g., a deaf person mainstreaming into a hearing school). Conversations about the disabled person’s negative feeling – the ugly, the non-redemptive, the depressed – remind the able-bodied person of their own potential disabled status, of their privilege, and of the ways they inhabit a world constructed with their needs in mind; thus, these topics are often relegated to private sessions with a therapist behind closed doors. Furthermore, mainstream society tends to language disability in terms of prescribed binaries – one can hear or they cannot, they can see or they cannot (Michalko, 2002). For example, Alex is perceived as “faking” blindness because he appears to have sight when he walks without a cane. Jaime is often seen as “not deaf enough” by her clients because she primarily engages with the hearing world. Total deafness is often more comfortable for a hearing person to contemplate than the range of auditory experiences across the spectrum of hearing impairment, which is ambiguous, messy, and not easily categorized. Thus, the hearing-impaired person must become even more deaf, more disabled, in order to be accepted by the hearing society who can then confidently place that person outside the norm. Here, I am reminded of Grace being told that she was high-functioning and could do fine without accommodations while the incoming blind student “clearly needed help” (MU 5.6).

My participants’ experiences crip the phenomenological notion of a therapeutic orientation that is normative, one that is auditory and visual. In the world of Erwin Straus (1966) and Merleau-Ponty (1962), spatial lines line up and disorientation lends itself to correction, such as when a person trips. They become temporarily disabled but quickly re-
align. But my participants cannot – and do not – wish for such correction. For those with divergent sensory experiences, orientation is less about re-aligning but about embodying and making transparent one’s umwelt in its current position; in other words, disabled bodies are shaped by the orientations they encounter (Ahmed, 2006; Iwakuma, 2002). A therapist who utilizes a cochlear implant in the session, such as Jaime, has made the object part of her embodiment; she has “a total awareness of [herself] in the intersensory world” (Merleau-Ponty, 1962, p. 114). Additionally, because the implant helps Jaime in her work with clients, by extension it also becomes part of her patients’ experiences as well. The structure of traditional analysis where the patient lays on the couch and the therapist sits behind them is not possible when one member of the dyad is deaf and relies on lipreading, another example that challenges the traditional “upright” structure of how and in what ways psychotherapy should be conducted.

Drawing again from the work of Erin Straus (1966), when patients perceive visual or auditory impairment in their therapist they are often “thrown,” decentered. If patients are open minded and curious, like with Octavia’s transgender patient, they can sit with their experience of being disoriented through a willingness to co-exist (Luijpen, 1960), to be-with their discomfort (Heidegger, 1962), to be challenged, to understand. Dis-ability, then, challenges the meaning of dis-orientation.

Moreover, a phenomenological model of disability cannot totally eliminate the notion of the body as an object, especially in the instance when a person becomes impaired later in life, such as Octavia. After becoming blind, her usual experience of embodiment became crpped and alienated; she became aware of herself as both object and subject. With respect to this dissertation, a phenomenological approach challenges conservative psychoanalytic thinking about disability and draws attention to the different lived
experiences of therapists with sensory disabilities and their impact on their work with patients. A phenomenological psychology of disability suggests that we need not to overcome the dis-alignment of the world but to reveal dis-alignment as an important perspective in challenging normative sociopolitical structures.

8.3 Looking ahead: Psychology and disability studies can join hands

Throughout this dissertation I have asked myself, “How can psychology benefit from incorporating a disability studies framework into interview and clinical practices?” A psychology disability studies methodology closely considers the intersectional and mutually constitutive nature of disability/ability and psychotherapy with attention to race, class, gender, sexuality, and other normative social structures that appear in the therapy dynamic or interview process. For example, when interviewing mentally ill patients, a researcher might consider how a participant’s experience of having a different mental relationship with the world has been shaped by living in a society that disables the mentally ill.

These findings also point to a need for an increase in accommodations in the workplace. It may be that because practicing psychotherapy is largely a solo activity, or at least perceived that way, those without impairments are not aware of the needs of their d/Deaf or blind colleagues. On the other hand, if it is up to the person with the disability to educate his or her colleagues, then such education will be impacted by their personal beliefs. For example, if overcoming disability is perceived as a sense of pride, as it is with Nadine, there may be less of an emphasis on educating colleagues about certain needs. If the attitude is not one of overcoming but of challenging sociopolitical structures, one might be more inclined to speak up about limitations within the workplace.

All of my participants have succeeded as psychotherapists, finding ways to adapt to a
world that is largely inaccessible or to simply reject that world and create their own. But this should not be their burden alone. It is the responsibility of the psychology community as a whole to step up and contribute to a more accessible and just world. For one, APA and other psychology institutions should implement training in disability studies, not disability issues, that latter of which often draws from the medical model in its curriculum. A few years ago the Association for Women in Psychology (AWP)’s annual conference was centered on disability studies and attracted a large number of deaf, blind, and other disabled participants. APA and other mainstream conferences could do their part by inviting more speakers and panelists who are doing work in disability and who also identify as disabled. The most important conversations about disability – the painful, the good, the surprising – are happening behind closed doors (i.e., between my participants and their patients). When the therapist shares something about the lived experience of disability to their patient, in an intimate space of safety, and the patient is able to take in the therapist’s words, not just intellectually but also on an embodied level, the narrative of disability changes. Such conversations need to occur on a larger, structural level, such as within the workplace or graduate training program.

These interviews also demonstrate how my participants frequently encounter what the phenomenologist Sara Ahmed (2012) calls the “institutional brick wall” – the resistance that those who are othered often face in the workplace and in graduate school. It is often only those who are confronted with the brick wall – which may be created by ableism, racism, sexism, or other power structures – who can see it. For those in the dominant group, the wall goes unseen (Ahmed 2012). Those without disabilities often believe that once they have admitted or hired those who are “diverse” no further work needs to take place. Simply the presence of having a deaf graduate student or a psychologist of color means the
institution has met some invisible quota; they feel good about being inclusive and believe there is no need for further conversation – except to ask intrusive questions, as I have recently discovered. When asked, “What is it like to be deaf and working at X?” I often think, in response, “What is it like to be hearing? To have power in being the director of this organization?” The term “diversity” has become a blanket, meaningless term that lacks an action-oriented discourse; that is, a critical understanding of and commitment to equity and social justice (Ahmed, 2012). In addition, the whole framework of “multicultural diversity” makes otherness a special topic cordoned off from a larger structure that is supposedly non-othered and normal.

As long as the person calling attention to the problem is seen as the problem, few changes will occur. My participant stories speak to what happens when they try to break down the institutional brick wall, or even call attention to it (as we saw in Grace’s interview when she pointed out how the sensors interfered with her ability to conduct therapy). Moreover, as diversity workers within the field of psychology, my participants attempt to “transform the [brick] wall...turning the tangible object of institutional resistance into a tangible platform for institutional action” (Ahmed, 2012, p. 175).

8.4 Suggestions for Future Research

The process of writing this dissertation has oriented me to possibilities for future research projects at the intersection of psychology and disability studies. My study looked at experiences of therapists with visual and auditory otherness. Future studies might consider other forms of disability and how they play out in the psychotherapy space. Additionally, incorporating client experiences and stories of working with therapists who are disabled would add a rich layer of depth to the current conversation. Expanding the population to
include d/Deaf therapists working with d/Deaf clients would also shed light in terms of how disability is experienced when both parties are members of the same culture. In our interview, Donna brought up the point that while disability impacts the alliance with hearing populations, she also “sees problems with the deaf community” with respect to working with d/Deaf therapists. She described feeling rejected by them because she wasn’t “deaf enough” (D6.5).

Finally, future research projects would do well to incorporate more participatory action research, a component that was not included in my project. My research utilized IPA as its primary methodology. While I believe this framework was the best choice by which to approach my focal question, the use of member check orients this project toward action or emancipatory research as a next step, where the researcher is the vehicle by which participants become empowered to take action against normative, disabling structures. By offering me feedback on my analyses and in talking with me about their experiences, my participants have educated the larger community about disability issues within psychology.

Still, this project is largely about individual experiences rather than enacting change on a collective level. For example, while Octavia is open and exploratory with herself and her clients, I wonder what it might be like for her to bring in more of this exploratory nature with her colleagues and trainees? She stated: “I often imagine what it would be like if everyone would sit in the room with their patients with their eyes closed. And how much more connected they might be?” (O15). Why not try this activity with them? Would they all feel more connected? Would they be able to better trust Octavia’s insights? Given how much I learned from her in our brief meeting, how connected I felt, and how much Octavia expanded my imagination, I suspect her colleagues and supervisees might feel the same.

Regardless of future directions, qualitative research must continue to problematize and crip
traditional structures, with the aim of further exploring the lived experience of disability within psychology.

8.5 Limitations of Dissertation

Despite the richness of my project, there are many limitations that come along with this study. For one, I am a beginning researcher in qualitative methodology. Using multiple methods was a struggle; I often felt I did not have a handle on any one method and worried that participant meanings got lost in my tendency to over code. That said, being a novice researcher also gave me the freedom to mess up without judgment from my committee, and to focus on the themes that I felt were most integral to my project.

As with all methods, there are limits to autoethnography, specifically the author’s use of anecdotal evidence as the subject for analysis. Yet, it’s important to remember that all research is subjective to some extent (Fassett & Warren 2007). Another critique of autoethnography is the use of emotion. Disability studies scholar Dana Morella (2008) states: “Positivist and post-positivist scholars argue…that emotion shouldn’t affect our biases and findings in research. Yet biases are present even before the research is begun” (p. 45). I would also argue that emotion is not just about feelings but also a site of knowledge-making, and appears even in the most objective of studies. Autoethnography also presents ethical concerns in terms of writing about others and the potential for harm; for example, my participants, my clients, and even my family may not agree with all of my thoughts. Yet I have tried to represent them with respect, beneficence, and with an eye toward justice.

Another limitation to my study is the high number of participant interviews. Initially I believed having a lot of interviews would result in better data but, in the long run, having 14 interviews made it challenging and frustrating in terms of organizing the data. I suspect
my anxiety about not getting participants contributed to my difficulty in cutting out interviews that were not as strong or capping the limit to a more manageable number. In this same vein, the high number of participant interviews made it difficult to do member checks with every participant, due to time constraints as well as the variability of strength across interviews. Reflecting back to my choices, I wish I had done member checks with all interviews, even those that were not as strong, offering participants a chance to read and reflect on their own interviews. That said, this dissertation is a work-in-progress and these themes portray just one way of looking at the data; in the years to come, I imagine I will revisit these interviews and see other relevant themes within the material.

8.6 Closing Reflection

On one level, this dissertation is about disability as it is experienced by my participants (and their patients). On a deeper level, it also about how otherness is discussed, tended to, and cared for as a necessary good to the society in which we live. This dissertation also demonstrates a kind of affective anxiety that takes place when talking about disability, even when such conversations are about trying to deconstruct and understand such anxiety. For example, the anxiety of being a novice researcher, the anxiety of not doing something right, the anxiety of offending participants, the anxiety experienced by participants when talking about their stories, and the anxiety around trying to break down normative structures and beliefs is the byproduct of what happens when disabled people are forced to adapt to a world that is not accommodating.

My participants taught me about determination in the face of adversity, about forgiveness and compassion toward oneself, about grace and kindness. In speaking out against lack of accommodations and microaggressions, and in openly discussing disability
with patients, my participants continue to break down barriers within and outside of the psychotherapy space. They give a necessary voice to an understudied area in psychology. Finally, my participants showed me how they have accepted – even embraced – the lived experience of disability in their work and lives through meaning-making, community-building, and knowledge-building.
References


178


Dear Participant:

My name is Kathryn Wagner, and I am a deaf doctoral student in the Clinical Psychology program at Duquesne University.

I am writing to invite you to participate in my dissertation research, which examines the lived experience of therapists who identify as having an apparent disability, and the co-created dynamic that arises in the therapeutic process when working with nondisabled clients. I am especially interested in interviewing those who identify as blind or d/Deaf, but would like to hear from all interested participants. This study is particularly important given that the lived experience of therapists with disabilities, and its unique impact on the therapeutic relationship, has not been fully explored. It is important that these voices become part of the growing literature on disability and psychotherapy.

At this time, I am interviewing only those therapists who identify as having an apparent disability and who are currently practicing therapy. For the purposes of this study, I define “therapist” as a licensed clinician (PhD, PsyD, LCSW, MFT, etc.) or a student-clinician or post-doc enrolled in a masters-level or doctoral-level program in clinical psychology, counseling psychology, school psychology, social work, or a similarly related field.

As a participant in this study, you will allow me to interview you one-to-one either at Duquesne University, at a location of your choice, or via Skype. The interview will take approximately 60-90 minutes and will include review of consent forms and a debrief discussion. In regards to accommodations, please let me know about your individual access needs.

There are no risks greater than those encountered in everyday life from this study. Confidentiality will be maintained, and you are free with withdraw your consent to participate at any time. This project has been approved by the Duquesne University Institutional Review Board.

It is my hope that you will find participation useful and enjoyable.

If you have any questions please contact me at wagnerk3@duq.edu or my advisor Dr. Lori Koelsch at koelschl@duq.edu

Thank you for your time.

Sincerely yours,

Kathryn Wagner
Duquesne University
Appendix B
Screening Questions for Participants

1. Please state your gender and ethnic background.

2. What is your degree (e.g., MSW, PhD, MA, etc.)?

3. Do you work in academia or identify as an academic scholar?

4. How long have you been practicing therapy? If you are in a training program or pre-licensed, please state how many years you have worked with clients.

5. Are you currently providing psychotherapy to clients individually, in a group setting, or both? Please describe.

6. Do you identify as a person with a disability? Please describe.

7. Do you consider yourself to have more than one disability? Please describe.

8. If you identify as blind, are you currently providing psychotherapy to sighted clients? If you identify as deaf, are you currently providing psychotherapy to hearing clients? If not, have you worked with this population in the recent past?

9. Do you need accommodations in order to conduct a face-to-face or online interview? If so, what are they?

10. Do you have a preference as to whether we meet face-to-face or online, and do you have a preferred location for the interview?
Appendix C
Consent Form to Participate in Research

TITLE: The Lived Experience of Therapists with Disabilities: A Phenomenological Analysis

INVESTIGATOR: Kathryn Wagner, M.A.

ADVISOR: (if applicable:) Dr. Lori Koelsch
Duquesne University
College Hall 537

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in Clinical Psychology at Duquesne University.

PURPOSE: You are being asked to participate in a research project that seeks to investigate the lived experience of therapists who present with an apparent disability and its impact the co-created dynamic that arises between patient and therapist. You will allow me to interview you one-on-one about your experiences. Interviews, either face-to-face or online, will take approximately 60-90 minutes. Face-to-face interviews will be audio and video taped and later transcribed for research purposes. Online interviews (via chat programs) will be audio taped and the chat message will be saved for research purposes. Email interviews are also permitted.

Transcribed data gathered from this study may be presented at professional conferences and/or published in academic journals. Video and audio recordings will only be shared with the investigator, advisor, and/or transcriber.

These are the only requests that will be made of you.

RISKS AND BENEFITS: Participants may feel some discomfort talking about the negative impacts of disability, but overall there are no risks greater than those encountered in everyday life. Your participation in the study will benefit the disabled therapist community in general.

COMPENSATION: Participants will not be compensated. However, participation in the project will require no monetary cost to you.
**CONFIDENTIALITY:** Your name will never appear on any survey or research instruments. No identity will be made in the data analysis. The consent form and any materials containing identifying information will be stored in a locked file at the Psychology Clinic. The videotapes, audiotapes, and transcriptions, which will not contain any identifying information, will be stored in a locked file in the researcher's home. All materials will be destroyed within two years of completion of the research.

**RIGHT TO WITHDRAW:** You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time.

**SUMMARY OF RESULTS:** A summary of the results of this research will be supplied to you, at no cost, upon request.

**VOLUNTARY CONSENT:** I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Dr. Lori Koelsch at (412) 396-1614 and Dr. Linda Goodfellow, Chair of the Duquesne University Institutional Review Board at (412) 396-6326.

________________________________________
Participant Signature and Date

________________________________________
Researcher Signature and Date
Appendix D
General Interview Questions

1. What are the major challenges you face in being a therapist?
2. What are the most important experiences that have shaped your development as a therapist?
3. How, if at all, has being deaf [or blind]* impacted your work as a therapist?
4. How has being deaf [or blind] influenced your relationship with your clients (e.g., therapeutic alliance)? Please tell me about a specific time when you have felt this impact.
5. How have you self-disclosed your disability to clients and responded to client’s questions about your disability? Please tell me about a time when you’ve self-disclosed that feels particularly meaningful or challenging to you.
6. Please tell me about a time you had strong feelings about your disability in response to a client’s comment or experience.
7. How has your disability influenced the ways by which you listen to and understand your clients? Please tell me about a specific instance that feels particularly meaningful or challenging to you.
8. How has your disability influenced your choice to become a therapist? What about your theoretical orientation?
9. How have your experiences in supervision and graduate training been impacted by your disability? How do you talk about your disability to others when they ask about it?

*I changed the wording depending on the client’s preference (e.g., preferred to go by hearing-impaired rather than deaf or visually-impaired rather than blind).
Appendix E
Initial Letter of Contact for Member Check

Dear Participant:

I hope this reaches you well. Thank you again for participating in my study. First, you may wonder why a lot of time has passed since we interviewed; I set aside my dissertation to focus on internship interviews last fall and winter. Since this spring, I've been hard at work transcribing and writing up the results from our interview (and interviews with other participants).

At this stage in my research, I am hoping to get feedback from you about our interview. Before that, however, I'd like to explain a bit about my methodology. My study utilized a form of qualitative research known as interpretive phenomenological analysis (IPA). This method aims to describe the participant’s lived experience in attempt to better understand the individual’s truths; it focuses on unique experiences rather than global truisms (Finlay, 2009). This method also gives the researcher space to speculate about participant experiences, to draw parallels between different participant experiences, and to offer tentative interpretations. Transcripts are analyzed line-by-line for possible meanings — both explicit and implicit — as well as underlying emotional reactions. IPA involves analyzing themes to create a narrative story that ideally highlights aspects of the participant’s life that seem particularly meaningful. Sometimes researchers will also draw attention to issues or topics that they are curious or have questions about.

If you agree to providing feedback, I will send you another email with a few questions and two attached documents: 1) the themes that were coded from your interview, and 2) my individual write-up of our interview (with focus on just one or two prominent themes). Please keep in mind that my questions will not be time-intensive; I mostly want to provide space for you to share whatever thoughts come to mind as you read through the themes.

Finally, it is my hope that the results of my study will increase participant action and open conversation between therapists with disabilities, specifically those who are deaf or blind. For this reason, I’m wondering if you might be willing to self-disclose your identity to the other participants in my study once I have finished my dissertation. At that time I can send out an email to those who have agreed and hopefully facilitate a connection. Other participants can serve as a future resource or support. You certainly do not have to decide now about self-disclosing, but I wanted to mention it as something for you to keep in mind.

Please let me know as soon as you can if you are willing to provide feedback on your interview. My IRB has been renewed for the coming year so if you agree I can send you the materials right away. Thank you again for your time, and hope all is going well.

Look forward to hearing from you.

Sincerely,
Kathryn Wagner
E.1 Follow-up Letter

[Decided not to send IPA Themes after correspondence with advisor. We thought it best not to overwhelm participants.]

Dear Participant,

Thank you for agreeing to give feedback. I have attached a rough draft of your individual write-up. If you would also like to see how I coded your interview, I can send you the list of themes. It’s a long document so I didn’t want to overwhelm you with it now.

A few things:

This attachment is a draft-in-progress: there might be some typos or notes that I haven’t fully fleshed out yet. Please also be aware that most themes in your interview were discussed in the overall analysis chapter (not included here) alongside other participant themes; your individual write-up focuses on one or two themes that I thought best captured your experience.

Your transcript was coded to include fillers (such as “uh” or “um”) and pauses. Including fillers allows me to ascertain moments of hesitation or uncertainty, moments where you might be deep in thought, moments when you were laughing, and so forth. I realize it may look awkward to have your thoughts represented this way but it is not uncommon to have a lot of fillers.

As you read through your write-up, please comment on whatever portions you’d like. A few questions to consider:

1. Are you comfortable with the way I represented your experience? If not, help me understand how I can better represent your experience. Again, keep in mind that this write-up is only aiming to capture one or two aspects of your experience.
2. Do you feel like your identity is accurately hidden? I assigned a pseudo-name to you but if you’d rather be called something else, please let me know.
3. Does this analysis provide you with new insights into your experiences? In what ways?
4. Do you agree/disagree with my findings — or do you have new thoughts you want to add?

Please be as honest as possible when providing comments. I’m aware that reading aspects of one’s interview (as well as getting feedback) is a vulnerable process but I’d really like to know what it was like for you to read this document. Finally, per IRB policies, please don’t share or publish any aspect of this document.

I am very grateful that I got to interview you and really enjoyed meeting you! I would appreciate getting feedback comments in the next few weeks. If you need more time, please let me know.

Thanks again,
Appendix F
Clustered Themes: Final Round of Coding

Challenges [14]

Challenges in General [7]
- Attachment Issues with Patients [1]
- Bracketing Self [2]
- Client Resistance [2]
- Ethics/Institutional Rules [3]
- Keeping up with Research [1]
- Time Limited Model [2]
- Time Management & Self Care [2]

Challenges as a Disabled Therapist [14]
- Accommodations [4]
- ADA [3]
- Anxieties in Relational Dynamic with Others [6]
- Client Populations & Therapy Modalities [9]
- Discrimination [5]
- Exhaustion Related to Lip-Reading & Impact on Self [5]
- Isolation & Lack of Community [8]
- Loss of Self-World [3]
- Implications of Passing/Not Passing [9]
- Self-Esteem Building Responses to Challenges [13]

Does Not Personalize [2 participants]

Impact of Disability on Therapy Processes [14]

Clients Use of/Response to Disability [11]
- Clients Response as Diagnostic for Therapist [4]
- Clients as More Understanding than Colleagues [3]
- Clients Belief in Therapist Ability to Empathize [4]
- Clients Belief in Therapist Ability to Overcome [4]
- Helping Behaviors Displayed by Clients [7]
- Unique to Blind Participants: Clients Desire to “Hide” from Therapists [4]

Effects of Disability on Therapy Alliance/Relational Spaces [11]

Therapist Experiences Disability as Fluid [3]

Power Dynamic Struggles Between Client & Therapist [5]

Psychodynamic Processes [11]
- Client Projections about Disability & Impact on Therapy [8]
- Transference-Countertransference around Disability [11]

Does not have an impact [3]

Therapist Process of Self-Disclosure [13]
- Client Response to Self-Disclosure [10]
- Styles of Self-Disclosure on Patient Reactions [12]

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The number after each theme includes how many of the 14 participants referenced this theme; used to determine the Major Table of Themes
Therapist Use of Disability [13]
   Body as Therapeutic Tool [6]
   Dog as Healing or Special [2]
   Facilitate Client’s Understanding of Self [4]
   Unique to Deaf: Positive Impacts of Mishearing Clients [2]
   Modeling/Psychoeducation [10]
   Unique Listening Skills/Non-Verbs [12]
Importance of Time on Self-Confidence [5]
Negative Impact of Disability on Therapy Career [1]
Positive Impact of Disability on Therapy Career [8]
Therapist View of Self [12 Participants]
   Impact on Beliefs [10]
      Accomplished [6]
      Anxieties about Success [3]
      Recognizes Limitations [5]
      Sees Self as Super Crip/Wounded Warrior [4]
      Disability as Having Personal Value [2]
      Must Fight Systemic Oppression [1]
      Minimization of Disability [4]
   Impact on Self-Esteem [10]
Effects of Positive/Negative Training Experiences [14]
   Growth of Colleagues/Classmates [7]
   Effects of Negative/Mixed Support [10]
   Effects of Positive Support [12]
   Therapist’s Growth [2]
Non-Verbs on Interview Dynamic/Interviewee Underlying Feelings [10]
Appendix G

Master Table of Themes for the Group
With Partial Excerpts from Transcripts

Please note that participant excerpts are often coded in more than one place here; within the dissertation, I attempted my best to discuss excerpts under only one theme. Any repetitions are an oversight on my part. Multiple examples of excerpts within same theme are separated with a line break.

Superordinate themes: Bold, caps, underlined, indented left
Subordinate working themes: Bold, underlined, centered
Explicit working themes: Underlined, indented left
Implicit working themes: Italic, underlined, indented left

A. GENERAL CHALLENGES AS A THERAPIST WITH A DISABILITY

MU1. Lack of Accommodations

1.1 Octavia: “Job Access With Speech […] doesn’t jive with the electronic medical record software […] doesn’t have accessibility features.”; “[Hurdles with the licensing exam] really need to be cleared.”

1.2 Jake: Lack of accessibility makes it difficult to “[access] the notes of case managers and psychiatrists.”

1.3 Alex: “The system at U-- in terms of accommodations for faculty and staff that have a disability, it’s not a centrally located element, and it’s all within the department.”; “[Rehab Services for the Blind […] the first couple years I was there they said they couldn’t do anything for me. They said they wouldn’t help me (laughing) because I had gotten an undergraduate degree or whatever.”; [Needs to be his] “own advocate.”

1.4 Jaime: Described having difficulty with getting access to interpreters and CART reporters due to lack of funding, institutional bias, and cultural expectations.

1.5 Grace: “We are required to record client sessions […] I was not able to not only not hear my own sessions but also the session of my cohort mates or supervisees […] so I was not able to give feedback.”; “We couldn’t even watch my sessions - I could not hear them.”

1.6 Donna: “For example, I have to audiotape sessions, no access to video, and some consultations take place over the phone or using videoconference that show people at a distance (can’t lipread).”

1.7 Nadine: “Because back in the 80’s when I was training there really wasn’t that much advanced computer technology, like text-to-speech and things like that. And so it was challenging to really work and do data analysis, and methods, and research methods, and that kind of thing. So in fact, I really didn’t get the level of exposure that my classmates did back then…”; “There were no personal computers either and my electric typewriter wrote out my papers.”
Challenges with implementation of ADA

1.8 Nadine: “You know, having the disability office, sometimes really, I think, compromises the abilities of our young people to really take ownership of their own problem solving around accommodations.” “They expect me to fix it, you know, and make the accommodation for them rather than coming with ideas as to what works for them. You know, I consider it a collaboration with the student.”

1.9 Sophia: “[Back then] there was no thought about accommodations [...] they could ask you about the disability. With the ADA they can’t exactly. So that’s what I mean for better or for worse [...] It became something that has to be more secretive, less out there and obvious. But there are still the protections.”

1.10 Anna: “I think in today’s job market of fearing discrimination allegations, [employers] tend to be quiet and not ask questions.”

MU2. Client Populations and Therapy Modalities

2.1 Brenda: “It can be very, very stressful [working with borderline patients]... their facial expressions, their behaviors, and having to think about it, to control my reactions, countertransference, trying to think and respond to them.”

2.2 Jaime: “When working with traumatized, trauma – especially abused, domestic violence, you’ll get borderline personalities and I worked a lot with them. I worked with too many. So I try to balance the high functioning ones.”

2.3 Melissa: Stated that working with eating disordered clients is difficult because she isn’t “always sure how accurate their view of their body is.”; “I am not keen on doing group work because I think my blindness is an impediment in this environment.”

2.4 Octavia: “Catering to the dual needs [of the couple] is challenging.”; “We were trying to decide how to administer the WISC and the WAIS. And that presented huge challenges.”

2.5 Sophia: “I feel like I did observe more than my co-leader was able to because my co-leader was attending to content. But in terms of carrying a group, it was not something I wanted to put myself into.”

2.6 Donna: Assessment can be difficult because she “cannot always ask for repetition and exact verbiage is important with some screenings.”

2.7 Alex: “I don’t do assessments.”

2.7 Anna: Doesn’t work with all-hearing families; needs the “natural alliance” of at least one deaf family member.

MU3. Isolation & Lack of Community

3.1 Nadine: “Not that many [...] it’s very sad” (about lack of blind psychologists).
3.2 Octavia: “Sorta – kinda [have a community]. Sorta. Um” (Laughs.) I belong to several list
serves for blind and visually impaired mental health workers. The greater number of those
individuals are – they come from social work. Um. And so their experience in some ways is
very similar, but in other ways very different. I don’t know any one of them personally or
intimately. And as far as a community of individuals who look like me, if you will, I don’t
have that. So. I-I-I….”

3.3 Alex: “It feels lonely. I’ll be honest. Even in the profession, even in the realm of [names
small city] the one psychologist that was blind working at [a governmental organization], he
moved away […] I don’t even know any other individuals that have physical disabilities of
any type that I would have immediate access to or could relate to. I would say there’s
definitely a loneliness in the profession. I would say that’s true.”

3.4 Brenda: “There are not that many hearing-impaired therapists out there!”

3.5 Jaime: “There are only a few deaf therapists…especially those with acquired deafness.”

**MU4. Passing as Nondisabled**

4.1 Donna: “I generally appear very ‘hearing’ meaning that people do not generally know
that I am HOH. Due to that, people tend to forget I may need accommodations and stop
offering. I then get tired of asking and usually let things go.”

4.2 Alex: “So like one time I was driving — not driving — but walking down the street and
crossing through an intersection of a pharmacy and somebody just drives out and hits me
and I go up on top of the hood of their car. And they apologize. Um. But okay. So what
does that mean? I have a cane and I’m a man, 6’ 4”. I’m not, like, invisible so why is it that
they can hit me?”; “I’ve heard people yell out the window also at me that he’s not really
blind, he’s faking it.”

4.3 Grace: “Oh well with the blind student we are able to see that she needs help – you are
too functional.’ So it became a question of visible vs. invisible disability.”

4.4 Bella: “I don’t know if I ever disclosed [hearing impairment] to the clients. I say that I
just didn’t hear you. They probably think that they [mumbled] or something like that.”

4.5 Ellen: “With my hearing aid my hearing is supposedly about 90-95% so I can use phone
(but often have to put it on loudspeaker, for instance depending on the sound quality).”

4.6 Jaime: “My career started to take off again when I got the implants”; “My deaf clients
come [to see me], ‘What are you?’ [they ask].”; “Or they have heard about me because I ha[ve]
a foot in the deaf world and a foot in the hearing world.”

4.7 Anna: “But I realized I didn’t really fit in either the deaf or the hearing world.”

4.8 Sophia: “I can’t hear at all, basically. But everyone in my life can. So I feel embedded in
that life, in this setting. I’m in a hearing world.”
4.9 Octavia: “Because if a patient is kind of continuing with the question, what is really going on with this cortical blindness. Those types of instances, they may question. ‘Is she really blind? She keeps saying she’s blind. She walks with that cane. But I’m not sure.’”

**MU5. Colleague Assumptions about Disability**

5.1 Octavia: “Where everyone else is worried. ‘She’s blind, she won’t see.’ ‘She might…’ and so there’s a hypervigilance about protecting me with peers and colleagues. They feel they’re going to have to run interference far more often than actually would be necessary. And I found that my medical director even has commented, ‘Wow, you sit right next to the patient, right? I’m scared that students will think it’s okay, because you’re comfortable and the patient is comfortable with you, but I know that a student wouldn’t be comfortable.’”; “On the day before the interview I was trying to schedule a cab. And the service in that remote area said, the lady told me don’t come out […] so I called the site and I said, I would need to reschedule, um, given this situation and I apologized and at that point I disclosed my blindness because that was the reason. And the supervisor said to me, oh, I’ve never had a therapist work with me who wasn’t whole […] I’m sure that there are some patients who would probably feel good to sit with you because you can’t see them. But on the whole, I don’t think that would be the case.”

5.2 Melissa: “The attitude that I find most difficult in relation to my blindness is when people are condescending or pitying, or both. This happens far more often outside the therapy room and particularly with [older] people.”

5.3 Bella: “When my colleagues joked about [my disability], I took affront and got very resentful and reactive. For instance one called me four eyes and said ‘Why don’t you wear glasses, you are acting a little stupid.’”

5.4 Alex: “And they [APA committee] wouldn’t provide [the assessment tests] in accessible format, because god forbid, I’d be on eBay selling them all” (laughing); “It’s an identity of having visual disability is very – it’s an odd place to be because people know what it means to be sighted and people know what it means to be totally blind because they can close their eyes and imagine what it is […]It’s not a continuum. They don’t understand it as a continuum.”

5.5 Nadine: “And the comment that I would get from them is, Nadine, we don’t see you as disabled. On one hand, that’s a compliment. But on the other hand, I want access to my materials. (Laughing.) And that’s a little annoying.”; “My colleagues are pretty impressed by some of the things I pick up and they don’t.”

5.6 Grace: “[My advisor told me they were] not used to disabled students at the PhD level.”; “[They believed she was relying on] “accommodations to get…through the work.”; She was “too functional” but the incoming “blind girl clearly needed help.”

5.7 Jaime: “[Colleagues would say] ‘you’re not deaf’ and ‘you can only teach deaf education.’”

5.8 Sophia: [The biggest barrier] is that of “getting in the door.”; “A lot of people, if they know in advance [about deafness] they don’t want to meet you, they just assume.”
5.9 Donna: “When I go out into hearing populations, I tend to get two reactions: sympathy/overkill in trying to address my needs, [or] doing nothing because I appear ‘hearing’.”

Discrimination from colleagues/workplace

5.10 Alex: “To be rejected in that manner and not even be given a chance essentially.”; “I felt that just in job interviews too at different points. I felt discriminated against because I had a disability. So as a therapist, in that way it affected me as a therapist, as well. Just not feeling I got certain opportunities that other people might have had if they didn’t have a disability.”

5.11 Jaime: “[I have to] fight for an interpreter.”

5.12 Donna: “I’ve been told by several different people that I have an ADA case and can sue the [government organization] but that would be such a hassle.”

5.13 Bella: “I really could read only very large print. I was expected to find files in the file cabinet (no computers) and I couldn’t. I was expected to read things that I cold not. I had to commence a lawsuit.”

5.14 Grace: “It finally came to the permission of the Dean of the school to turn all these sensors off. These are his responses when the IT director bought it up to him: ‘Who the hell does she think she is? Those sensors cost us money. Can’t we buy her new hearing aids? Can’t we keep her in the basement in the clinic?’ and ‘What do we need to do to keep her quiet?’”

MU6. Exhaustion Related to Lipreading [Unique to Deaf Participants in this Interview]

6.2 Anna: “[I wish my clients with accents] would find another therapist!”

6.3 Jaime: “You’re reading constantly, your eyes are being used 24/7 practically. And other times you sit there and you just close your eyes for a minute and how they burn and you’re thinking I’m just so tired.”; “Lip-guessing.”; “Only 30% of English language is visible on the lips.”

6.4 Sophia: “I would say one of [the challenges] is the structural stuff where there’s clients I still, no matter how hard I try, I just cannot hear. They talk too softly, or they’re depressed and their voices are way down and they’re not showing very much.”; The exhaustion of having to lipread a fast-talking client leaves “less opportunity for responsiveness.”

6.5 Grace: “There is this ego depletion or exhaustion if you will that I think all disabled individuals experience in trying to function in an abled body world – for me I feel like sometimes I am too tired to hear and do not have the strength or energy to try to hear anymore that day.”
MU7. Grappling with Ongoing Anxieties

7.1 Brenda: “Anxiety, of course.”

7.2 Donna: “Losing my job and confidence in my skills.”

7.3 Sophia: “Self-conscious.”

7.4 Jaime: “I also think about one of the major challenges for me that’s very painful is, in the beginning people would call me for referrals and I would refer them out. My own therapist was yelling at me, ‘What are you doing? You’re a damn good therapist. What are you doing?’; ‘Because I was still losing my hearing, I wasn’t totally deaf. I was losing my hearing at the time and was very sensitive about it. So any time I was very self-conscious […] I used to wear my hair longer so you couldn’t see the hearing aids.”

7.5 Melissa: “I remember when I first started working as a social worker I would get very nervous about greeting new people in the waiting room and bringing them back to my office. I would often worry that people would refuse to see me due to feeling that I wouldn’t provide as good a service due to being blind.”; Also feels “self-conscious” at times with various patients.

7.6 Octavia: “‘No, no, Dr. […] always sits right there.’ So they’ll protect my territory or whatever. And so sometimes I’m concerned about that dynamic. And so I find that what it causes me to do is, maybe hyper-elevate a student. Right? I keep emphasizing, this is my colleague, this is my colleague, when in all actuality, this is a trainee who’s under my supervision. But because I want to, almost normalize, it causes me to adjust how I would […] elevate the trainee, if you will.”

MU8. Responses to Challenges

8.1 Ellen: “Lipreading with kids can be challenging for sure but I’ve been lucky to help them understand I need to see their faces when they are talking.”

8.2 Sophia: “But then there are those that do. They mumble. They, um – let’s see, they talk too fast. They don’t pause. They don’t create opportunities for me to stop them and try to clarify things. And boom, boom, boom, boom, boom, on they go. And yes, I let a lot of that go.”

8.3 Jaime: [What’s] “intense” and “painful…will come up again.”; “You do so much more to get to the starting line. We’re all so wiped out and everybody else it’s like, go. That’s why it’s so important for us to, you know, self care (Laughing).”; “I had a supervisor during my internship. She told me one thing that stayed with me all these years, something comes up and you miss it, [it’s] not so much because of the deafness. If you miss it in therapy relationships, ‘Oh, I wish I’d said that during this time,’ or, ‘I should have’ — you know how your mind is going a million miles a minute? And you’re doing your observation and you’re listening and you’re listening to what’s not being said and the whole thing? It will continue to come up. Until it’s resolved.”
8.4 Alex: “I probably would have done it differently now than I did then, but I tried to be very real with who I was […] People can accept me if they want to. Or not accept me. But if they’re going to accept me I want them to know kind of the whole package of who I am. And not just pick and choose parts of me. Um. So I think there was that. And also coming to a greater integration of who I was and that’s an ongoing process…”

8.5 Bella: “I explained that being blind was not a game, was not fun and was not something to be taken lightly. The class became silent and the professor was quite embarrassed and I think I taught him more than he taught me that semester.”

8.6 Octavia: “That has been incredibly rewarding. For me, realizing the greater purpose and helping someone with a mental health issue has been incredibly rewarding. Because before my brain injury, I didn’t – I had taken coursework in psychology, I didn't value what was actually happening in those processes. And so to be forced into it by virtue of career, it’s opened up my eyes.”; “So the blindness was something that I had to – overcoming what it means to be blind was huge to me.”; “To avoid [premature questions about disability] I will throw it out there and let them know that at any other time we can certainly discuss any curiosities [patients may] have.”

8.7 Anna: “But you know, if I see any kind of discrimination at all, I will use that. I comment on it.”

8.8 Melissa: “The other thing that sometimes comes up is clients telling me that they saw me somewhere outside of the therapy room but weren’t sure what to do about that. We can then talk about how they would like to manage that in the future. I also always ask clients where they work if they have some paid job as I like to choose whether I will go to that place. I feel that I need some prior warning as of course cannot see who is serving, etc. as I approach a store or cafe.”

“It’s not about me”: Learning to not internalize or personalize

8.9 Sophia: “I also feel like if someone tells me I can’t help them, I don’t personalize that because I generally think that’s wrong. I can help them. So in those kinds of situations. If someone tells me I can’t understand them, I’ll think about that.”

8.10 Nadine: “What you have to do is kind of separate yourself and try to understand the dynamic and that it’s not personal. I’m an object, I was an object to that person.”

8.11 Ellen: “One woman was a paranoid schizophrenic with delusions and very concrete thinking so I did not take her rejection personally because it seemed to fit with her symptom pattern, she latched onto my hearing as a reason I would not be able to understand her because I couldn’t ‘hear’ her.”

Going above and beyond: Accomplishing more than most as a response to challenges?

8.12 Anna: “But when I got my PhD, I think maybe there were twenty PHD’s across the country. Maybe. In fact, in California we only have – I can count the number of deaf psychologists on my hand out in California.”
8.13 Nadine: “So in fact, I really didn’t get the level of exposure that my classmates did back then. But I did enough to be able to finish. And now actually I have a career development award from NIH that is actually filling the gaps.”; “On internship and practicum, really no issues at all. I went in initially, people knew I had the disability when I came in. And you know, I just talked to them and said, ‘Here are the accommodations I need,’ and I talked about my role in problem solving, and this is what we can do. So it’s not that I expected them to make accommodations. It’s here’s what I can do.”

8.14 Brenda: “I have high expectations of me to understand everything and to follow what is being said.”

8.15 Octavia: “So there are severe suicidal ideations, acts, borderlines, psychosis. Um, mania. A lot of bipolarity. Schizophrenia. You name it we see it. Transgender issues. The whole – literally the whole gamut.”

B. SUPPORT DURING TRAINING & RELATIONSHIP TO SELF/OTHER

MU9. Graduate School Support & Relationship to Positive Views on Self

9.1 Alex: “I think one thing that I would highlight is some important teaching experiences where I was a student under the guidance of professors. So that’s one. Working with faculty that were challenging and encouraging and supportive. And really invested themselves in my growth and development as a professional.”; “Supervisor was totally blind. And that was one of the reasons I ranked the place to go there for internship.”

9.2 Anna: “Mentors were good about asking me questions, and my relationships with them was more authentic. I stayed in touch with all of my mentors throughout my life.”

9.3 Melissa: “I also am part of a Gestalt peer group supervision and we meet once a month to talk about our work from a Gestalt perspective.”

9.4 Octavia: “But I said in the interview with APA, [being at H---] allowed me to feel dignified in my blindness. And that dignity allowed me to become competent in my practice, or to begin to develop competency and confidence.”

9.5 Sophia: “So what could be done was my supervisors trying to tell their colleagues, you know, wait a minute. She can do the job. She was fine here. Give her a chance.”

9.6 Ellen: “They check-in to see how it’s affecting my work from time to time but it doesn’t appear to lessen their confidence in my work at all, generally they have been quite supportive.”

9.7 Jaime: “She told me one thing that stayed with me all these years, something comes up and you miss it, not so much because of the deafness. […] it will continue to come up. Until it’s resolved.”

9.8 Brenda: “Very positive. Univ of --- and community planning. […] It worth being in a
world where you can interact with everyone, such as the deaf, hoh, late deafened, and hearing, and it helps decrease the isolation.”

9.9 Melissa: “I felt that my trainers were very accepting of my having a disability and were willing to learn alongside me how I developed as a therapist. I really liked the way they honored my experience of knowing myself and my prior experience of living with a disability so that idea of me being an expert on myself”; “I feel very respected by my colleagues in my workplace. Colleagues will come to me to debrief or ask my opinion about something and I equally feel very comfortable going to others for help or assistance when I need to.”

Negative Graduate/Supervisory Support & Impact Overcoming Behaviors/Denial of Disability

9.10 Bella: “In graduate school one of the professors thought it would be fun to pretend to be blind. He had the class close their eyes and walk around bumping into each other and into inanimate objects. So many were giggling, what a fine old time! I of course did not participate and when questioned why, I explained that being blind was not a game, was not fun and was not something to be taken lightly.”

9.11 Donna: “Currently, the administration and my supervisors are the ones making rude comments. For example, my supervisor assumed I misunderstood someone because of my hearing loss. [...] I didn’t say anything. I had already been called ‘defensive’ when trying to explain my point of view so I did not feel safe to share my thoughts freely.”

9.12 Nadine: “And you know in some way he was right, because I didn’t have the access to the labs, and you know, the methodology, data analysis because the technology wasn’t there. So maybe that’s what he meant. [...] and that, I think was the only one – but, you know, it’s one that lasted through my graduate career.”

9.12 Jake: “Well, yes. I was the only visibly disabled student and trying to find readers, there was no disabled student program at that time. There were no personal computers either and my electric typewriter wrote out my papers. It was not an easy time.

Mixed Support in Graduate School as Contributing to Realistic Views on Self-World

9.13 Alex: “I did feel discriminated – and I did get access.”

9.14 Donna: “Internship was very accommodating because they had a deaf wellness center and were very familiar with HOH/D needs. I did my internship at the University of medical center. This was my first experience with the [agency].”

9.15 Sophia: Loved grad school but found the academic and clinical job market “both very difficult and both trying to shut their doors.”

MU10. Positive Impact of Disability on Psychotherapy Career

10.1 Alex: “I think a lot of the factors [as to why I went into psychotherapy] had to do with the reality of my disability and I was diagnosed with a rare form of cancer when I was two
years old and lost most of the sight in my right eye and all the sight in my left eye. So I think there’s an inherent appreciation for people that either experience different life experiences and maybe experiencing some level of emotional pain in their life.”

10.2 Octavia: “The brief story is I had a brain injury and I had a life reinvention. I was left blind and with a wide array of deficits, and psychology became a transition point for me. I had always been curious about people. Um. And then it was almost – an opportunity opened up through what happened.”

10.3 Anna: “Why did I go into psychotherapy? I think for a very obvious reason. I grew up orally. And was lonely in a hearing world. And I was inspired by my first therapist […] I realized I didn’t really fit in either the deaf or the hearing world. She was wonderful and I studied psychology in education in college, decided that I wanted to work with deaf people.”

10.4 Nadine: “Well, I would say my experiences around oppression and then on the other hand, problem solving with regard to my disability have shaped the way that I work. I became visually impaired at the age of 16. Prior to that I was part of the majority, so to speak. And so I really had to problem solve and advocate for myself and so that’s my spirit in teaching clients to advocate.”

10.5 Ellen: “[Disability] contributed to my depression and also to being a keen ‘observer’ of other people.”

10.6 Brenda: “I became a therapist to understand myself […] I never had a therapist who understood the deaf and hard of hearing and because of that I became I think a better therapist.”

10.7 Sophia: “I would never tell anyone that I couldn’t hear if I could avoid it, I would avoid it […] I would say mostly heightened my awareness of communication.”

10.8 Grace: “My disability changed the way I saw individuals - the way I saw a diagnosis and a disorder and the way I saw human beings.”

Psychotherapy Career as Healing Process from Loss or Trauma

10.9 Octavia: “That has been incredibly rewarding. For me, realizing the greater purpose and helping someone with a mental health issue has been incredibly rewarding. Because before my brain injury, I didn’t — I had taken coursework in psychology, I didn’t value what was actually happening in those processes. And so to be forced into it by virtue of career, it’s opened up my eyes.”

10.10 Jaime: “I have a lot of experience from how I grew up. I grew up in a terrible situation. I was older than I should have been at that age. I was street smart and too mature.”; “And I would be pretty honest in saying, it’s natural for me. (Laughing) But also, I grew up in a home that was — had an [abusive caretaker]. In the old days they didn’t have rules for domestic violence and all that stuff. So unconsciously, somehow it led me into being a therapist.”
**MU11. Importance of Time & Experience on Self-Acceptance**

11.1 Anna: “Of course, the oddness of how to handle my hearing loss with hearing clients have definitely gotten better through the years. Going from wanting to ignore it, not talk about it. To now I am very open about my hearing loss.”

11.2 Jaime: “It wasn’t until I was 40 that I said, I’m deaf. That’s it, I’m deaf. And really feel strong that I’m deaf. But you get that ostracized in the deaf world too if you’re not culturally deaf or born. I was dealing with that in the early part of my career.”; “But with my hearing clients, [having the implant], it’s like I come home and I feel more confident. I feel like more me.”; “So I think, I try to be a little step back, and not so anxious with that. And this comes with experience over the years that I’ve been able to sit back and be like, you know?”

11.3 Alex: “Well, I think all through high school, even my young adulthood, again, the reality, I didn’t want to feel different […] I think I didn’t have the confidence, probably in myself, or the esteem in myself. So I think it actually did help, you know, going into the doctoral program actually because there was such an emphasis on multicultural — a greater emphasis on greater multiculturalism living in a pluralistic society.”; “And there’s a bit of a coming out process, quite honestly. Accepting and embracing my disability.”; “I think I’ve become maybe less tolerant of stuff over time (laughing) and just being more direct and to the point of things.”; “I wanted to be out there, I didn’t want to feel like I was hiding anything or not disclosing. And again, letting people decide. This is who I am, take me or leave me.”

11.4 Melissa: “As time has passed and my experiences grown my disability has become far less of an issue than it was in the beginning […] I guess that I feel that my blindness is far more integrated into the way in which I work. […] In the past I may have attributed my being blind to a specific piece of work that a client did or a comment they made etc. but now […] it’s like as I have become far more comfortable with my blindness as a result of doing my own therapy and through settling into my role as a psychotherapist I think that it is not such a part of my client’s experience of me as their therapist.”

11.5 Jake: “My own confidence in my abilities seems to offer a security of my clinical abilities.”

**MU12. Acceptance of Disability Parallels with Growth as a Therapist**

12.1 Alex: “But I also recognize as somebody with a disability, but I also feel very, very privileged. I have all kinds of privileges as an individual with a disability.”

12.2 Anna: “The more open I am with my hearing loss, the less [clients] underestimate me, and therefore they respect me. In fact, what I found is that when I don’t deal with my hearing loss it presents a lot more problems.”; “I feel a sense of pride in seeing how clients and others can see me as a person first, and my disability second.”

12.3 Nadine: “I became visually impaired at the age of 16. Prior to that I was part of the majority, so to speak. And so I really had to problem solve and advocate for myself and so that’s my spirit in teaching clients to advocate.”
12.4 Sophia: “But so much about a disability is internalized and really it takes a while to separate from that and to recognize what are the true limitations and then because they’re there. And what other limitations because people who can’t hear, say they’re there.”

12.5 Octavia: “That has been incredibly rewarding. For me, realizing the greater purpose and helping someone with a mental health issue has been incredibly rewarding. Because before my brain injury, I didn’t — I had taken coursework in psychology, I didn’t value what was actually happening in those processes. And so to be forced into it by virtue of career, it’s opened up my eyes.”

12.6 Grace: “Naturally dealing with multi-systemic oppression had influenced me to conceptualize in a systemic way and a feminist/multicultural way (multicultural needs to be a theory soon!) - how has family, society, culture, neighborhood, history and so on influenced this individual?”

MU13. Disability as Overcoming: Supercrip/Wounded Warrior

13.1 Alex: “Wow you’ve overcome so much. You’ve not let your challenges defeat you or be a barrier […] and there’s probably some truth to it. But not let my disability defeat me and that.”

13.2 Nadine: “N: And they somehow see a connection with me. And they talk, and they talk more to me than they would an able-bodied therapist.
I: You notice they talk to you more than other people there?
N: Yeah, Yeah Yeah, you know. Because the commonality is, they’re marginalized, I’m marginalized. And so, you know, they understand what oppression is and they understand what being marginalized is. And they get the fact that I understand it, too.”

13.3 Grace: “The irony of it all is that I have had more direct client hours than anyone.”; “There were a lot of meaningful moments centered around me ‘getting it’ or understanding it. This is with all clients.”; “Well, let me tell you something - my clients - all of which are low SES and low level of education - had no issue with me being hearing impaired or disabled. When I had to conduct a session without hearing aids - they said not a problem and basically talked very loud and made sure I can read their lips. They did this without a second thought. It was automatic for all of them. They always offered to talk louder and I never had to tell any of them to repeat or speak clearly or uncover their mouth.”

13.4 Jake: “Her response was that I am the only one that is trying to see her for her and doesn’t judge her or try to change her or tell her that all the things she is doing are wrong. She felt that I got her because rather than focus on her questionable behaviors I was trying to see why she was making those choices and what was the original root of her motives.”; “The most important experiences have been those where change occurred, aided by my interventions. The angry man who allowed me into his home and allowed me to help him towards achieving a driver’s license; the young woman who spent her high school years looking at the floor who became a socially active college student; the man with a schizophrenic disorder who stood proudly in an Elvis costume and sang on stage; the mother who changed into a more responsible parent— her son said — I want my old
mother back; the young man who decided to use his anger to get back at his step-grandfather by graduating high school; and more and more.”

13.5 Octavia: “And I said, help me understand what it is that you love. And she said, you can’t see me so you’re not judging me and I feel like I’m more of a woman in your presence than in anyone else’s. And so there was this kind of idealized role that I had stepped into just by virtue of being blind.”; “Sometimes individuals connect with the fact that there’s a brain injury or that something happened to me in my life, so that life alteration provides hope. Or people, clients will say – you’ve gotten over – you’ve gotten through.”; “Patients want to continue. They want me to be their therapist and I’m not in private practice. So they’re calling and they’re saying, oh, Dr. C--, I had this experience, what do you think about that? And although I will refer them, they sometimes will even circle back. They will have seen the therapist and then they call back and say, oh, he or she wasn’t like you, I want to work with you.”

**MU14. Clients More Accepting of Disability than Colleagues**

14.1 Bella: “When I was at the agency there was little to no understanding of my disability. It caused a lot of frustration and hurt that other therapists were so callous. Most of the clients were very helpful [and] let me write or they would write large or read to me. My colleagues were not at all as understanding as my clients.”

14.2 Donna: “The problems I am having now are related to supervision and consultation, not with clients. […] With clients in therapy, I have not had an issue. If I miss something, I ask them to repeat.”

14.3 Melissa: “The attitude that I find most difficult in relation to my blindness is when people are condescending or pitying, or both. This happens far more often outside the therapy room and particularly with people in older generations to myself […] Thankfully this doesn’t happen very often [with clients] though and I think this is largely due to the younger generation being far more comfortable and more exposed in their daily lives to people with disabilities.”

**MU15. Disability Reduces Power Dynamics**

15.1 Sophia: “For patients who talk a lot and who talk fast, then too much of my energy has to go into getting what they say and there’s less opportunity for responsiveness. For patients who generally have a conversation with me, where I’m welcome to comment any way, they create more process, they create more spaces.”

15.2 Octavia: “So that blindness, allowed a space of trust. And I had shared with you, sometimes I think it just provides a space for openness. Because people feel less exposed.”; “Now, there’s a positive component with patients and clients, because there’s something about the blindness that is an equalizer, right? So they, for whatever reason, may not feel as exposed. Or they may feel more willing to open up because some things are just innately covered because I can’t see them.”
MU16. Using Therapist's Disability to Hide/Be Seen [Unique to blind participants in this study]

16.1 Alex: “In some cases I think it actually can be a positive thing. In the sense that maybe they don’t feel like I’m judging them or looking at who they are in that much detail. That I’m looking, maybe or experiencing them more internally about what they’re talking to versus externally where they might be talking more about their feelings, so really connecting more with that versus outwardly appearance.”

16.2 Jake: “Some patients have appreciated my blindness, saying that they feel less judged by their appearance, this especially from patients with body image concerns.”; “There have been several examples, most commonly with folks with body dysmorphic disorders, voicing their relief that I was unable to see them. People are, likewise, interested in telling me about their weight loss/gains, their attire & the like.”

16.3 Octavia: “I wasn’t as aware until I had a client who was transgender at the hospital. Male to female. And she said to me, she said, I love sitting with you. And I said, help me understand what it is that you love. And she said, you can’t see me so you’re not judging me and I feel like I’m more of a woman in your presence than in anyone else’s.”

16.4 Melissa: “Often with clients who have an eating disorder they will say that they feel comfortable with me as they feel I won’t judge them on how they look. They like that I can’t see them and notice whether they have put on and taken weight off.”

MU17. Disability Impacts Therapy Alliance in Positive Ways

17.1 Sophia: “And in many cases, it has strengthened things just because they know I’m trying. They know I’m really paying attention. Um. Eye contact for me is almost constant. And let’s see. Uh. So I think they can feel that. They can feel my interest and attention and genuine desire to hear them and communicate with them and understand them.”; “Some clients feel I’m going to understand them better because I’m going to know what it’s like to be left out. I’m going to know what it’s like to have hurdles. Um. Things to overcome. That kind of stuff. So some clients may feel it’s going to work for us.”

17.2 Brenda: “But I know that when I and the client get to know each other and communicate with each other the deafness part fades away. When we focus on the relationship. Same that I do with the deaf and hard of hearing, picking up body language reflecting back [...] I think it goes back to having and building a relationship.”

17.3 Melissa: “Depending on where they are at in their course of therapy I might ask them how they feel around my blindness. I would only do this if I had established a relationship with them however.”

17.4 Alex: “Again, I think there’s a rapport building, there’s a strengthening of relationship by being able to have somebody sit across from you that can relate to that. Um. So I think there’s power in that. I think there’s times when people are going through hard times themselves and it may be something completely different than a physical disability issue, but, um, they — I think it can be therapeutically beneficial to them to know that I do understand
what it means to be different. And I do know and understand what it means to be discriminated against. And I do understand an aspect of what it means to hurt or those types of things or feel alone or feel those types of emotions.”; “So for example, I worked in a mental health group home for five years and I think that, severe persistent adult mental health, and I think I related differently to the patients and the folks that were residents in that group home versus other stuff. And I think they recognized, again, that I appreciated who they were. I treated them like people. They didn’t feel, like, different or inferior or something just because maybe they were lower SES or different ethnicity than I was. I think maybe they were able to connect with me and I with them at a different level just as a positive benefit of having the disability.”

17.5 Grace: “It has helped me understand the ‘other point of view.’ I see every individual both abled and disabled both minority/majority as a multicultural being and also from a systemic view […] Thus, coming from the disability view allowed me to see the client from their view as a minority due to gender or due to low sea or what their life is like due to trauma or divorce or whatever their issue may be. It made me willing and able to shift into their perspective and try to see it as they see it…”

17.6 Nadine: “I think it’s really pretty straightforward and having that animal has been very helpful [to establish] rapport.”

17.7 Ellen: “I think it may actually enhance the alliance at times with some kids who have trust issues with adults; while there are moments of frustration when I miss something a child has said that they need to repeat they are usually okay, and other times they have curiosity and questions about my hearing loss.”

C. IMPACT OF DISABILITY ON TRANSFERENCE AND COUNTER-TRANSFERENCE REACTIONS

MU18. Understanding Client Projections’ About Disability

18.1 Anna: “Underestimate my skills because of my hearing loss.”; “When a family comes in they already know, they’re shocked when they have a deaf therapist. They’re shocked. Really? It gives them hope for their own. They can have a job. You know?”

18.2 Octavia: “[Many clients] believe that blindness is the worst thing that could ever happen to anyone (jovial).”

18.3 Alex: “Sometimes I think my clients may think I can’t see but I can hear better than other people. Or I listen more effectively, and I don’t necessarily agree with that.”

18.4 Octavia: “Sometimes individuals connect with the fact that there’s a brain injury or that something happened to me in my life, so that life alteration provides hope. Or people, clients will say — you’ve gotten over — you’ve gotten through. So I can be hopeful because I see that it can be done.”

18.5 Sophia: “[Many of my clients have assumed that I am] literally not going to be able to
understand them.”; “But it’s also genuine and they’ve been able to, when I ask them about it say more about what it’s based on, and it’s always based on something they assume about me. But you know it’s like, that’s okay with me. If it’s working for the therapy, they can assume what they want. (Laughing.) If it works against the therapy, I’ll clarify.”; “When they don’t stay with me, and there are some who don’t, and I think because of that. It might be someone, let’s see, if they know in advance and think, oh, I don’t think that’s going to work. And so they may change their appointment before they even meet me.”

18.6 Jaime: “[The Deaf assume] that I cost too much [because I have a PhD].”; “Because you have, if I say I’m straight, what are they going to say? If I say I’m gay, what are they going to say? It’s not about me, it’s how they’re feeling about themselves.”; “But I also had a lot of clients who fall in love with me because I was paying attention too much…so I had to deal with that, I think, maybe more so. I really pay attention. I try not to be too conscious of staring at them or lipreading.”

18.7 Nadine: “There was one person, and it happens mostly with Axis II narcissistic personality disorders, they literally said, I don’t believe I got a therapist with a visual impairment. That they got somebody that was flawed that way. Because they consider themselves as entitled […] I would process it with them. And say, you know it sounds like you’re really having a reaction to me right now. And so we talk about it. You know? […] What you have to do is kind of separate yourself and try to understand the dynamic and that it’s not personal. I’m an object, I was an object to that person.”

18.8 Melissa: “[I will often get people saying, ‘There are a lot of people far worse off than me’ – and I think they are directly referring to their realization that I am blind and they can see but at least once they have verbalised this feeling we can then work with it.”

Helping behaviors allow clients to feel more in control?

18.9 Bella: “When I could read sometimes the clients (they were almost all young people) would either make jokes or become extremely helpful. I felt that impacted the relationship because some wanted to take care of me (laughs).”; “I think that for some of the clients it was eye opening, they could feel for someone other that themselves. For others it perpetuated the caregiver role that they had in their families […] they were almost all victims of some sort of violence or witnesses to this violence.”

18.10 Jake: “Some patients feel a need to describe twitching or eye rolling to me…”

18.11 Grace: “When I had to conduct a session without hearing aids – they said not a problem and basically talked very loud and made sure I can read their lips.”

18.12 Sophia: “A not rare, but less common response is, ‘Is there anything I should be doing differently?’ ‘Should I talk louder?’ They want to know what it means for them. That kind of thing.”

18.13 Octavia: “She wanted to make me happy.”

18.14 Jaime: “You know sometimes about another thing with hearing clients, sometimes they
MU19. Understanding Transference Reactions with Respect to Disability

19.1 Octavia: “And I said I’m curious about that, help me understand what is it about me, what makes me more trustworthy? And he said, ‘I can’t imagine what it’s like to be blind and in a room with a big guy that everybody says is a criminal. And it’s just you and me in here and I don’t feel like you’re paranoid or afraid of me at all.’ ‘But you can’t see me.’ ‘You don’t know what I’m doing.’” “In our termination process, she brought in a recording and the title of the song was Blind Mary. And she played it for me and cried. And I recognized my own kind of grappling with that. She said, “you have made such an impact on me that when I heard this song it made me cry. So I recorded it and I wanted you to hear it.” For me, I was wondering, ‘A’, the significance of the blindness. But also recognizing the significance of the relationship. And how the relationship again would have changed had I not been blind.”; “And sometimes I use it – (pause) – I use it to kind of reflect on maybe some familial dynamics where we’ve idealized something or someone. I’ve used myself as an instrument for the process.”; “In certain instances there are family dynamics where the parent has been idealized for whatever reason. ‘My mother’s the president of this bank.’ And to recognize how it is to be called to task as this child of this parent. You have to hyper-perform. You have to over-accomplish. You have to exceed. And so sometimes using our relationship, while I’m wondering what it feels like to be here in the presence of your therapist, and I won’t tell your blind therapist. But I recognize I’m idealized and I’m blind and I’ve overcome. So using the relational dynamic as recognizing that it’s related to — not calling attention to that— but allowing the client to recognize. Wow. It’s like my relationship with my mom. And I think of you as my mom and I’m glad that you’re here for me. So allowing that space of exploration and understanding without boldly, kind of, calling that link to their attention. But recognizing within myself, oh I must be mom today.”

19.2 Jaime: “But opposite sex definitely leads to transference. But because of deafness, the thing we have to pay attention to, a lip reader here or we’re very observant. In the hearing culture not so much. With deaf clients, [they say things like], ‘You understand me.’ ‘We can communicate,’ ‘you’re deaf like me, you speak, you sign,’ ‘I can’t meet anyone else like you, let’s go out for a drink afterwards,’ and ‘can’t you make an exception?’”

19.3 Jake: “One patient, a woman with a schizoaffective disorder stated that she felt more comfortable with me as a blind person, but later told of having been raped by a blind man while in college. The transference issue was right out there on the table. We discussed it and her reactions. Her deceased fiancé was visually impaired as well as it turned out later, complicating things further. It is all grist for the mill, as would any transference issue. Blindness issues were not, really, a feature of treatment, but she was overweight and did say that she was glad that I was unable to see this. She did display some attachment issues with me; for example she gave me an impulsive hug following a session in the facility lobby. She was upset, knowing that she had transgressed a boundary. We had to process that a bit later on.”
MU20. Using Transference to Facilitate Client’s Understanding of Self

20.1 Anna: “With a quiet client, they’re surprised when I say to them, ‘You know, I’m having a hard time hearing you and I’m wondering if other people in your life also have a hard time hearing you.’ And what I thought I would hear is, no, not really. But in each case, they say, ‘Yeah, you’re right. People say that.’ And then that opens up a way for exploring that more. And what I find is that the quiet person, the client, there’s big issues underneath being quiet.”

20.2 Grace: “Well it made me see a lot of characteristics that others may see as symptoms/criteria of a disorder I realize that they were not part of a disorder but rather as a coping mechanism in dealing with the everyday challenges of his disability. Also some of the maladaptive coping styles were merely survival tactics that he learned on his own.”

20.3 Octavia: “And then on other days, it can be – I can be challenged by it. And sometimes I use it – (pause) – I use it to kind of reflect on maybe some familial dynamics where we’ve idealized something or someone. I’ve used myself as an instrument for the process.”

Exploring countertransference reactions requires vulnerability?

20.4 Octavia: “So recently a client had — as I had shared with you — sometimes they want to nurture me and this particular client was in the session very much trying to gratify and appease me. Being hyper-compliant and for me it brought about the experience of others. Others, my children. Or other colleagues. And I found myself becomingagrivated and agitated as she was working to condone, comply, you know, appease me. She wanted to make me happy. And for me I was angry about my blind — I felt it within myself. My own growing resistance to her need to appease me. To nurture me. To coddle me. And she wasn’t doing it overtly. But she was kind of — as I would offer an interpretation, she was going with me far too readily.

I: Were you able to talk with her about the stuff that would come up for you?

Octavia: Yeah, and so it went on for a few minutes in the session and then I paused. We had a moment of silence and then I kind of asked what was happening for her. And I disclosed that I was aware of some feelings that were coming up in me and she kind of spoke to her mother having had blindness later in life and her mother being very directive and dictatorial and her need to please her mother. And then it made sense to me. But I also recognized, almost like some semblance of projective identification. Somehow I had taken on this kind of role within myself, I had recognized something had been called out in me. And I was angry. I went, please stop it, stop it, stop it, trying to appease me. I want you to listen and I want you to figure it out for yourself. This is what’s going on in the background. It certainly wasn’t coming out. It was very much therapeutic, right?”; “And sometimes I use it – (pause) – I use it to kind of reflect on maybe some familial dynamics where we’ve idealized something or someone. I’ve used myself as an instrument for the process.”

20.5 Jaime: “So I got defensive. I just said – uh, (laugh) – I was stunned and I was angry and I didn’t know how to — I never felt that much anger in a session before. But I know that was my mother issues, too (laugh) or the lack of mothering. She was being overly mothering. I thought she was being very selfish, too. There was a lot going on.”; “So when I see a client who’s feeling very depressed, I have to continue to remember that my frustration is a mirror
of what they’re feeling. I mean that’s a key point of countertransference. So before I would focus on my own frustration and I would get anxious. But now I realized that, okay, turn it back on them. So I’m aware. And then I give it to the client.”; “When I meet people who are deaf like me, I’m professional, highly educated, and working on their own and I find myself sometimes attracted like we all do with some of our therapy relationships. And I’ve had to be on my toes about that and I think part of that is, wow I wish I could walk out the door and meet someone like that. You know? Because we don’t have the pick and choose — you know in the hearing world you date somebody. And then they break up, you never see that person again. In a deaf world, oh, god, everybody’s been with everybody. I’ve had clients — oh, I’ve been married to him. That’s my ex-wife and he’s married to my best friend now. But it’s a small world. Any small cultures you’ll see that.”

20.6 Jake: “As with many patients I had some attachment issues with this patient as well, perhaps some sexual fantasies. The rape and the romance with blind men did help to enrich these fleeting fantasies.”; “After she earned her MSW degree she again contacted me to supervise her towards licensure. She has a hearing impairment as well as her blindness. Perhaps I feel some competition with her; perhaps I am frustrated by her youth; perhaps I am responding to her differences, race and sex; perhaps I’m responding to her clinical limitations; however, it does seem that my counter-transference is based on her dedication to me as a mentor […] Thinking through it I feel that my uncomfortable with her is with her neediness. Apparently I have some of the same issues. I recall a youth telling me of being sexually abused and thinking how glad that it had not been me, only later to recall that it had happened to me in a similar fashion. I think that her blindness issues may be some of my own issues that I would rather not address.”

20.7 Sophia: “So you know, that I’m putting them [narcissistic client] out by needing more from them in order to communicate. That is a countertransference reaction to me. Yes, I feel annoyed and I feel less motivated to help them. All that stuff. Something to work with” (Humor to voice).

MU21. Using Countertransference to Further Self-Growth

21.1 Melissa: “At times I will pick up on projective identification, projective or disowned aspects of the client which are felt by myself. I am learning to differentiate these from my own responses that may be counter-transferential and need to be bracketed and taken away to work on later in therapy or supervision.”

Countertransference reaction to patients with certain privileges

21.2 Alex: “The only thing that immediately comes to mind is, I work with some clients that have, like, drank alcohol and drove. Or used drugs and drive. And I kind of get pissed at them. Not only because I don’t tolerate that, endangering other people. I don’t have any judgments, if people want to drink they can drink as much as they want, whatever they want. It’s when it crosses the line into putting other people at danger I’ll be pretty confrontative about that. But I’m not cool with that. That that’s not cool. So there may be something else behind that in terms of, well, I can’t drive. I wish I could drive and here you are able to drive and you’re driving really stupidly by being drunk and driving and putting yourself and everybody else at risk. So there might be kind of in that type of situation. And they may carry over into other economic stuff. Even with advanced technology, it’s not easy to read
for me or I read a lot slower than other people and when people aren’t even trying or they
don’t even read the book or buy the book and not using their education as much as they
could, maybe that sense of countertransference or maybe jealousy on my part. I wish I had
what they had, it would have made my life a lot easier than it was in terms of doing a degree
and stuff like that.”

21.3 Melissa: “I struggle specifically with that attitude of them seeming to feel that they
should just be able to have whatever they want in life with no real effort or sacrifice. I don’t
think I feel jealous of them but I do feel irritated at times by their fairly narrow view of life.”

Taking care not to over-identify with patient’s disability

21.4 Anna: “I used to identify mostly with a deaf client when I first started therapy. Now, I
try very hard to look at things more objectively. I’m trying to give you an example. For
example, I think one of the classic mistakes that deaf therapists have is that they tend to
over identify with the deaf client and excuse behavior because of the deafness. But I’ve
learned over the years not to do that. So for example, I might excuse Axis II behavior saying
it’s because of the deafness. And in actuality, it’s Axis II. It’s not about the deafness. So if I
see Axis II behavior, no, I don’t identify with the deaf client. I might identify with certain
things. But not with the person. On the other hand, if I have a client who is Axis I, yeah I’m
more inclined to maybe identify with the client.”; “So when I see a client who’s feeling very
depressed, I have to continue to remember that my frustration is a mirror of what they’re
feeling. I mean that’s a key point of countertransference. So before I would focus on my
own frustration and I would get anxious. But now I realized that, okay, turn it back on them.
So I’m aware. And then I give it to the client.”

21.5 Grace: “Sometimes with the disabled client I would assume he feels the same way I feel
when he faces discrimination or prejudice or hardships - but I quickly learned that is not
always the case and I stopped allowing my experiences to get in the picture.”

MU22. Client Responses to Therapist Disability: Diagnostic Cues

22.1 Anna: “I’m sure. (Laughing.) I just can’t remember right now. Not really. I have found
that the discomfort is more mine than theirs. I have noticed — well, actually, if it is negative,
I see that as being diagnostic.”

22.2 Nadine: “And you know, I’ve had a few clients who, I, um, I conceptualize as psychotic,
and you know what she does? She has a bed under my desk and she doesn’t even go near
them. She goes in her bed. And rolls up into a ball. She doesn’t interact with them.”

22.3 Melissa: “My main experience of this is working with people who are on the autistic
spectrum or who may not yet have been diagnosed but yet their responses to my blindness
indicate that they relate quite differently to their peers. These people will come across as
being quite clumsy and/or intrusive in how they ask me questions about my blindness. For
example — how long have you been like that? or just walking over and patting my guide dog
without asking first. I have also had the odd occasion where a client has brought another
person into the session and hasn’t introduced them. I have sensed that there is somebody
extra in the room and asked who is there.”
22.4 Alex: “And I worked with him and he worked with me and I thought we had a good relationship. But the first session he came in he had a – again the mannerisms of that – he waved his hand right in front of me, he stood up and waved, can you see me? (Laughing.) You know? So, just odd – it was an odd type of thing.”

22.5 Sophia: “Interestingly enough it’s not the people for whom it’s realistic that feel that way. It’s the people who are more worried it’s part of their clinical presentation feeling isolated or let’s see. Feeling misunderstood in general that I’m going to get caught in that, in their own way. A very literal way.”

D. THERAPIST PROCESS OF SELF-DISCLOSURE: FINDING THE RIGHT FIT

MU23. Self Disclosure Styles

23.1 Alex: “Then I talk about it. I actually bring it up. I’ve gone through different stages where initially I thought I needed to talk about it. And then there was a period of time when I didn’t talk about it at the beginning of meeting somebody. And now I just lay it out there at the beginning and I give a couple sentences, a brief self-disclosure about it.”; “So then I kind of swung the other way and didn’t do that for a while. And then I don’t know why I swung back the other way. Maybe just because I wanted to be out there, I didn’t want to feel like I was hiding anything or not disclosing.”

23.2 Anna: “And it goes something like this. I say, ‘Hello. Before we get started let me tell you a bit about myself. I’m hard of hearing. And what that means is I do hear you some and I lip-read you. And there may be times I might not understand you and there might be times you don’t understand me. And if at any time you have a question, please ask me. And if I don’t understand you, I’m going to ask you to repeat it. And if you’re not comfortable at the end of the session about working with me, no problem. I’m happy to refer you to one of our other therapists.’”

23.3 Brenda: “I always do [self disclose at beginning of session]. I would look at them after introducing myself, check in and see if we can understand each other. I take full responsibility.”

23.4 Donna: “In the hearing community, I tend to only disclose when relevant. For example, when explaining why I am asking them to repeat or if they have hearing issues. My hearing clients have been appropriate with my disclosures. Hearing clients don’t tend to ask follow up questions but I would answer them if they did. With deaf clients I am open too because that is the culture. You share much more with deaf clients than hearing.”

23.5 Nadine: “My self-disclosure process is that I, um, let students know – first of all, as I walk in with them, I don’t go out with the dog to the waiting room. So I say, you know, I have a visual impairment, I want to let you know that I have a guide dog, are you okay? Most students are fine.”; “You know, I answer them and I assure them that that’s not going to interfere, my disability is not going to interfere in any way with what they’re going to get. And you know, really, the focus is about them. I have had rare occasions where clients wanted to talk about the disability or wanted to talk about other things and it’s to distract,
you know, it’s to distract from focusing on them, so I said, you know, really this is all about you.”

23.6 Ellen: “Mostly I make a point of telling folks right off the bat to make sure I can see them when they speak, and put them at ease to feel free to ask questions about my hearing loss, but without taking the focus away from their issues to me too much.”

23.7 Grace: “I tell them in the first session – I am a [names ethnic background] immigrant disabled female that moved into the cornfields of [small city] from [big city] – I disclose all of it and assure clients that the fact that I am different from them is not going to be a hindrance but an asset to therapy.”

23.8 Jake: “I greet patients with my white cane in hand when I first great them in the lobby, then escort them back to my office. In that time they recognize my blindness as well as my ability to negotiate the confusion of hallways in the facility. I invite questions about my blindness or about any other aspect of our meeting. I ask for them to read and complete consent and agreements, explaining each form as it comes to the top. Usually by the end of the initial session my computer has had to speak or my braille note-taker has been employed. Some folks ask questions, some don’t.”

23.9 Sophia: “And another thing I learned is not to tell them right away. Not to start out with it. It creates more anxiety than it stops […] because the client has already had an interaction with me and is realizing that I am getting things and so on and so forth. So they have a more realistic idea of, um, when I say that I don’t hear well. I let them know that I don’t hear, um. I hear by lipreading. I see what they say. That the telephone, for that reason, doesn’t work for me. So that’s the kind of information I tell them. If I were to tell them in the beginning, it’s their image of what that’s going to mean. When I tell them later in the session they already know what that’s going to mean.”

23.10 Octavia: “So often I will speak to perception and how misperception is how we all kind of often end up in the hospital. Because either we’re misperceiving how we’re feeling or others. So I will say — so for me I am cortically blind and I’ll explain that. And then I explain, the reason I’m explaining this is because I wouldn’t want anyone to raise their hand in group, your arm would get really tired because I won’t ever see your hand in the air. And sometimes that will prompt questions. Often that will prompt questions and I will defer the questions. I’ll say, you know — I will acknowledge the questions but not in the group dynamic.”

23.11 Melissa: “I am very open with my clients about my blindness and refer to my blindness in the first session and introduce my guide dog. I set the scene for them to feel free to refer to it if they feel the need […] During the first session I talk a little bit about the way in which I work and as part of this I just mention that I am blind and let them know that as part of that I will sometimes ask them to elaborate on what is going on for them due to not being able to see their facial expression or nonverbal cues.”

23.12 Jaime: “No, if they notice, then I’ll say, yeah, but usually it doesn’t come up.”; “Psychologically, I don’t want to risk the rejection of— okay, I’ll say I’m deaf or I have trouble hearing and you come back and give them the choice. I’m afraid they’ll hang up or
they’ll come and decide they never want. I never lost a client where they actually showed up.”; “You know, I can use humor appropriately with the right client in terms – or say, okay, ‘Could you say that again?’ Or sometimes I go, ‘Do you mind repeating that?’ Or, ‘I missed that again, oh, gee it’s loud outside.”

MU24. Patient Reactions to Self-Disclosure Vary and May Point to Transference/Diagnostic Issues

24.1 Nadine: “No, most clients are cool about it. You know, that’s fine. They want to focus on themselves.”

24.2 Anna: “I have to say, I’ve only had one client, one student say to me, I want to work with another therapist.”

24.3 Ellen: “I did have a couple adult clients who felt I couldn’t ‘hear’ them (literally and figuratively I suppose) and one child whose guardian was uncomfortable for whatever reason with my hearing loss, but 3 people out of several years of practice is not too bad :)

24.4 Octavia: “I had one person in all of my life who seemed to have a challenge with [my blindness]. My externship year, he was a hurricane Katrina survivor, had been displaced, and was here in DC. And this was some years after that. And when I shared that with him, he said, these are his words. “Oh, ‘F’ no, I can’t take another one.” And what I took from that was — yet another person with a troubling issue. I need to be — I need to be upfront and the most important individual in this. And for me to disclose my blindness it was like, wow. No more, I can’t take anymore. And so he and I discussed that. And he said it wasn’t about the blindness. He was just overwhelmed with all of the things that he had to deal with and so he would prefer to work with a therapist where there wouldn’t — he perceived that as maybe it was something else [experiences with Katerina] coming into the room. Beyond that no one else have ever — as a client.”

24.5 Jaime: “Her issue, it wasn’t so much with my deafness as much as it was her son was mentally ill with a disability. Her issue with disabilities per se, and I’m sitting across from her with a disability. And her need was to keep her son with a disability depended on her”; “She said, ‘What’s up?’ I said, ‘I’m sorry I interrupted you, battery died,’ with a little bit of humor. She looked at me. I said ‘I have implants, I don’t hear very well without them.’ ‘Oh, okay.’ No big deal.”

24.6 Brenda: “Some go right ahead and keep talking about their problems. Some became a little stunned. Some act like it isn’t a problem or they want to be sure that I can understand them. Different reactions.”

24.7 Donna: “Deaf clients vary – either they are happy that I have some hearing loss or unhappy that I’m not deaf enough.”

24.8 Grace: “Yes either positive or neutral – most have not cared to be honest and just talked louder or clearer and to my surprise I never had to remind them again.”

24.9 Melissa: “The way in which clients respond to this is interesting. Some will reassure me
– oh, that’s fine – whilst others will just acknowledge it or say something about my dog.”; “I have never however had a client tell me directly that they don’t want to work with me due to my blindness. I have had clients contact my manager and ask to see a different therapist but I figure that this experience isn’t specific to me and there are multiple reasons for this.”

24.10 Jake: “This experience of their own areas of blindness seems to help them to see blindness in my own terms, as a bother and nuisance, but not as a disabling condition. I see this brief exercise as psycho-education and evaluate if the patient is able to extract from this experience to other areas.”

24.11 Sophia: “Most of my patients say, you know, they’ll say something that’s just, ‘That’s fine, that’s okay.’ Let’s see. A rare response is that, Um. ‘That could be good for me, I should probably slow down anyway.’ Let’s see. A not rare, but less common response is, ‘Is there anything I should be doing differently?’ ‘Should I talk louder?’ ‘They want to know what it means for them.”

MU25. Function of Self-Disclosure: To Model/Psycho-Educate Patients

25.1 Alex: “I think it can be therapeutically beneficial to them to know that I do understand what it means to be different. And I do know and understand what it means to be discriminated against. And I do understand an aspect of what it means to hurt or those types of things or feel alone or feel those types of emotions.”

25.2 Anna: “When I work with families, where there’s a deaf person in the family, I will use my experience growing up.”

25.3 Ellen: “But I feel that’s beneficial if kids that feel ‘different’ due to whatever circumstances brought them to therapy find they can talk to an adult who has been through some challenges and overcome them.”

25.4 Grace: “That exhaustion from having to function in an abled-world and knowing what that is like has helped me with my disabled client tremendously - he thought it was just him and him not doing good enough - disclosing about me and my experiences and the experiences of others has helped him understand himself as a disabled person and how he copes and manages and how he sees himself.”

25.6 Jake: “I have used myself as a model to some patients, saying that due to my blindness I have had to learn to do things differently than others, as they with ADHD might, too, need to do things differently.”; “This experience of their own areas of blindness seems to help them to see blindness in my own terms, as a bother and nuisance, but not as a disabling condition. I see this brief exercise as psycho-education and evaluate if the patient is able to extract from this experience to other areas.”

25.7 Melissa: “I will often give examples here about my own experience as a way of normalizing how we all struggle with different things. I will say for example about how I used to feel anxious about greeting a new client in the waiting room or how when I was much younger I would feel anxious about finding a new shop that I hadn’t been to before but how with practice and experience and feeling more comfortable with myself these things
have lessened.”

25.8 Jaime: “I’m more on an interpersonal relational psychodynamic type of approach. Between the therapist and the patient. Use that as well as modeling. Rather than the old blank slate.”

25.9 Anna: “I feel a sense of pride in seeing how clients and others can see me as a person first, and my disability second. As for working through their issues, I believe they see their disability(ies) in a new light. My hope is that they can learn to see that their disability doesn’t have to define them; that they can see the glass as being half full rather than half empty.”

25.10 Nadine: “And so I really had to problem solve and advocate for myself and so that’s my spirit in teaching clients to advocate.”

E. THERAPIST USE OF DISABILITY TO INTERPRET CLINICAL CUES

MU26. Body as a Therapeutic Tool

26.1 Anna: “Yeah, I definitely have to use my nonverbal skills. I think I need to add that I used to be a dancer, so I’m very aware of body cues. So I use my skills and knowledge as well. I don’t call myself a body therapist. But I use body awareness as a big thing.”

26.2 Nadine: “Well, um, certainly it’s made me become more attuned to what’s going on in a therapy room. So I’m very attentive to looking in more detail at things that I may not be able to see. So I kind of try to pick up non-verbals in other ways. (Slight laugh).”

26.3 Octavia: “Sometimes when I’m working with students, or even peers and colleagues, to recognize the use of self as an instrument in the process is vitally important. And so yeah we study all kinds of theory and we’re told if they do this and they do this it means this. But sometimes we leave ourselves outside of the experience.”

26.4 Melissa: “I have also had the odd occasion where a client has brought another person into the session and hasn’t introduced them. I have sensed that there is somebody extra in the room and asked who is there.”

26.5 Alex: “I don’t know if I’ve asked a client if they’re crying. I think I’ve asked a client, it seems like you may want to cry or need to cry and give that invitation, but I don’t necessarily ask for clarification, are you crying or not crying? I open the door to try to create a safe place for them to cry if they want to. And validate and normalize that it is okay. Let those emotions out.”

MU27. Unique Listening Skills/Non-Verbals

27.1 Anna: Yeah, I definitely have to use my nonverbal skills. I think I need to add that I used to be a dancer, so I’m very aware of body cues.”

27.2 Brenda: “I am more empathetic and sensitive. I pick up their feelings and their body language.”
27.3 Donna: “I think I am more observant with my clients. That comes from being a strongly visual-based person, which I think is related to my hearing loss. I’m usually very observant in two areas 1) appearance 2) demeanor. I can usually tell how people are doing by the way they take care of themselves and dress. Also, I am observant to their demeanor, as in, being able to tell if something is making them uncomfortable or they may be lying by their body posture. Colleagues have not commented on this skill.”

27.4 Nadine: “I pick up a lot by tone of voice. And I can actually say to a colleague of mine, I bet that person is rolling their eyes right now, and she said how did you know?”, “I can also hear when clients are fidgeting or if they’re cracking their knuckles or things like that. So I can hear the movement kind of happening. I have one chair that squeaks (laughing), so you know, I can hear the squeaky. It’s probably not as visible to the clients, it’s not observable, but I know.”

27.5 Sophia: “I had a contribution to make from the nonverbal piece. I feel like I did observe more than my co-leader was able to because my co-leader was attending to content.”; “And sometimes when I say something back there’s the disconnect because it’s obvious they said this and I said this. Okay. Let’s see. Usually I can tell from their expression that something was wrong. So I’ll say, did I say the wrong thing or did I miss something? Something like that.”

27.6 Octavia: “I think blindness causes me to be more patient sometimes because I’m going to wait and listen for it. Sometimes it allows me greater attunement, I believe. I will sit in the room with colleagues and we’ll all listen to the same interview and there are so many nuances that you just kind of naturally expect everybody would have picked up, and for whatever reason, I’m not sure if it’s – I’m not sure what happened…”

27.7 Melissa: “I notice things like whether they are fiddling with things or moving around a lot which often denotes anxiety. I take notice of the tone and intonation in their voice. I suppose I can smell whether they are clean or whether their hygiene is poor. I also just ask what’s going on for you and get them to verbalise more their feelings etc.”

27.8 Jaime: “When I was deaf I’d look for the throbbing vein in your neck (Laugh.) . It’s going to be more obvious than not. You know sometimes about another thing with hearing clients, sometimes they notice I’m watching them more intensely more so in the past, and they’re like, you all right? You’re staring at me. Or are you lipreading me? Then we’ll have a conversation about it.”

27.9 Jake: “Some patients feel a need to describe twitching or eye rolling to me, however they soon feel that I can ‘hear their eyes rolling.’”

F. INTERVIEW DYNAMICS HIGHLIGHTED IN THE HERE-AND-NOW

MU28. Participant Desires to Help Interviewer

28.1 Alex: “I don’t know if there’s things I’ve not responded to that could help you in your dissertation and this research that you’re trying to create for yourself.
28.2 Grace: “I am curious if your focus was more on clients reactions to disability in the therapy session?”

28.3 Octavia: “So disclosure [around internships], I certainly would assess the site before.”

28.4 Jaime: “But if you find something in an intense moment...then I think you will find a way.”

**MU29. Participant Sees Self in Interviewer**

29.1 Brenda: “When I was young I was very brave like you, but now too tired to advocate or to speak up in a new hearing place. It doesn’t change maybe the therapists have never met a deaf or hard of hearing person so it makes no sense to educate all about deafness if they will never meet one again. Interesting report you are doing but I can relate to what you must be going thru now.”

29.2 Anna: “Even when I was young, I couldn’t understand the lyrics. So don’t feel bad.”

**MU30. Interview Dynamics as an Illustration of Therapist’s Work with Patient**

30.1 Nadine: “You know, and sometimes some clients of my colleagues, you know, they’re seeing other people in the counseling center, they know I have a dog. And when they see my office door open, my colleague often bring their clients in so they can say hello to Savannah. It’s very interesting.”

30.2 Octavia: “Sometimes when I’m working with students, or even peers and colleagues, to recognize the use of self as an instrument in the process is vitally important. And so yeah we study all kinds of theory and we’re told if they do this and they do this it means this. But sometimes we leave ourselves outside of the experience. So for example, you coming in here with me, you brought yourself into the room so you’re allowing yourself to really engage in this exchange.”

30.3 Jaime: “It’s been nice to talk to someone about — someone deaf like each other.”

*Humor as defense against anxiety within interview or painful memory?*

30.4 Alex: “And I worked with him and he worked with me and I thought we had a good relationship. But the first session he came in he had — again the mannerisms of that — he waved his hand right in front of me, he stood up and waved, can you see me? (Laughing) You know?; “Well, the first couple years I was there they said they couldn’t do anything for me. They said they wouldn’t help me (laughing) because I had gotten an undergraduate degree or whatever”; “I’ve heard people yell out the window at me that ‘he’s not really blind, he’s faking it.’ You know, I’ve had people laugh at you, people honk the horn at you. Yell at you” (Laugh).

**Minor Table of Themes**

**Minor 1. Loss/Loss of Self**

Octavia: “She said – she had me late in life, and she used to say, ‘If I ever get so I can’t see,’
— that’s exactly what she would say — ‘let me die, because I don’t think I would ever want to live if I couldn’t see.’ And something that’s poignant about that is that my mother passed away two months before my brain injury. So the blindness was something that I had to — overcoming what it means to be blind was huge to me.”

Jaime: “And any way, so [a family member] committed suicide when [I was] 19.”; “That was that life-death personality from growing up.”; “I have a lot of experience from how I grew up. I grew up in a terrible situation. I was older than I should have been at that age. I was street smart and too mature.”; “And then I lost the – the deafness lost that – I’m not going to make up time. In retrospect I wish I would have got my MD in psychiatry or clinical psych because of all the politics going on now.”

**Minor 2. Negative Impact of Disability on Therapy Career**

Donna: “In a negative way, I think this postdoc has pushed me backwards as they are very critical of my work and have taken experiences away from me.”

Sophia: “Until basically, until the job search.”

Grace: Not getting as many experiences to have videos watched/translated; general stress around lack of accommodations results in hospitalizations.
Appendix H
IPA Individual Analyses

Please note that participant excerpts are often coded in more than one place here; within the dissertation, I attempted my best to discuss excerpts under only one theme. Any repetitions are an oversight on my part. Multiple examples of excerpts within same theme are separated with semicolon.

Interpretive Phenomenological Analysis
Participant Themes with Excerpts from Transcript
“Octavia” (Face-to-Face)

Super-ordinate themes shown in bold and underlined
Working themes shown in underline
Working implicit themes shown in italics
Textual support cut and pasted from transcript
[Thoughts about theme in brackets]

O1. Disability as opportunity to experience self/world in new and positive ways: as a “life reinvention” and something that “opens up” her eyes
“The brief story is I had a brain injury and I had a life reinvention. I was left blind and with a wide array of deficits, and psychology became a transition point for me. I had always been curious about people. Um. And then it was almost – an opportunity opened up through what happened.”

“I was left cortically blind, unable to walk or talk or breathe on my own or feed myself. Um. Just everything that we take for granted.”

“For me, realizing the greater purpose and helping someone with a mental health issue has been incredibly rewarding. Because before my brain injury, I didn’t – I had taken coursework in psychology, I didn’t value what was actually happening in those processes. And so to be forced into it by virtue of career, it’s opened up my eyes.”

“But I said in the interview with APA, [being at Howard] allowed me to feel dignified in my blindness. And that dignity allowed me to become competent and competent in my practice, or to begin to develop competency and confidence.”

O2. Octavia’s worldview and curiosity about past influences speaks to her psychodynamic orientation
“My worldview is very psychodynamic though. So. But when working with patients and clients, to be pigeon-holed in such a way doesn’t work. Doesn’t work. So I tend to look at what the need is and then go from there.”

O3. Octavia’s acceptance of blindness meant working through mother’s comment
“My mother had always had an interesting aversion to blindness. She said – she had me late in life and she used to say, “If I ever get so I can’t see,” – that’s exactly what she would say – “let me die, because I don’t think I would ever want to live if I couldn’t see.” And something that’s poignant about that is that my mother passed away two months before my brain injury.
So the blindness was something that I had to – overcoming what it means to be blind was huge to me.”

[Orientation might be connected to her working through her mom’s comment (maybe in therapy while in graduate school). She never got to talk to her mom about subsequent blindness.]

**O.4 Sense of accomplishment from going above and beyond?**
“So my day is pretty balanced because on the one hand, on the unit I’m trying to work with someone to try to find the motivation to stay alive and then when I go downstairs, the units on six, patients are fighting to stay alive.”

[She gets meaning out of what she does – this comes through in her language and description.]

**O.5 Curious and questioning about self-other experiences**
“You know, what am I going to do with this? How am I going…”
“And so sometimes I’m concerned about that dynamic.”
“…and I’m not sure what role blindness plays in that, but I’m certain that it changes that dynamic.”

[Thinks things through, wonders about impact of actions on others, reflective, thoughtful, etc.]

“I will sit in the room with colleagues and we’ll all listen to the same interview and there are so many nuances that you just kind of naturally expect everybody would have picked up, and for whatever reason, I'm not sure if it’s – I’m not sure what happened.”

[Not sure “what happened” since being blind and having this kind of non-verbal experience? Since blindness she’s had to connect on a different level with people – this level seems to go deeper. But most others can’t join her at this deeper embodied level because of being sighted.]

**O.6 Aware of strengths and limitations**
“And I am – to acknowledge my limits is difficult.”

**O.7 Major challenges are not centered around disability but nature of job**

**Time Management**
“Time management is a beast. To acknowledge my limits is difficult. And so I tend to spread myself hyper-thin. And so that can be really challenging. Beyond that I would say kind of dealing with – some of the ethical issues with patients can be challenging as well.”

**O.8 Patients desire to continue with O.**
Patients want to continue. They want me to be their therapist and I’m not in private practice. So they’re calling and they’re saying, oh, Dr. ---, I had this experience, what do you think about that? And although I will refer them, they sometimes will even circle back. They will have seen the therapist and then they call back and say, oh, he or she wasn’t like you, I want to work with you.”

[She is well-liked by patients.]

**O.9 Patient risk of suicide**
“Or sometimes when they’re walking on the edge, when things are fragile and, you know,
what am I going to do with this? How am I going – and usually requires my advising them to come to the hospital. Because in order to be able to assess up front. But those kinds of questions can be challenging.”

O.10 Challenges as therapist with a visual disability mostly occur with colleagues, supervisees/experiences anxiety around preferential treatment

O10.1 Challenges around meeting needs of couples
“Couples work – it's challenging for me. It's hard.”
“I had one person in all of my life who seemed to have a challenge with [my blindness].”

O10.2 Challenges with Assessment Testing
“We were trying to decide how to administer the WISC and the WAIS. And that presented huge challenges.”

O10.3 Feels like she has to do above-beyond to meet expectations of sighted colleagues.
“…huge hindrance because the expectation or the understanding is one of deficit. So peers, around me, feel – I have to do extra.”

O10.4 Experiences her colleagues as fearful of disability
“So there will be agitated patients and I'm comfortable doing some compassionate de-escalating. Talking them down. Where everyone else is worried. “She's blind, she won’t see.” “They might…” And so there’s a hypervigilance about protecting me with peers and colleagues. They feel they're going to have to run interference far more often than actually would be necessary. And I found that my medical director even has commented, “Wow, you sit right next to the patient, right?” “And I'm scared that students will think it's okay, because you're comfortable and the patient is comfortable with you, but I know that a student wouldn't be comfortable.” So those, those kind of fears, and, they're more related to my blindness than anything else, are communicated by peers and colleagues.”
[Disability increases anxiety outside therapy room with colleagues. They express their anxiety with surprised or a question or a fear rather than with understanding. Her colleagues see her disability from a medical model perspective – they have such a radically different perspective than what Octavia's actual experience is like.]

O10.5 Experiences outright rejection from potential supervisors/persons in authority
“So I called the site and I said, I would need to reschedule, um, given this situation and I apologized and at that point I disclosed my blindness because that was the reason. And the supervisor said to me, oh, I've never had a therapist work with me who wasn’t whole. And I was stunned by that.”
“I've seen them present at conferences, I didn't know they really practice.”

O10.6 Professional challenges
“So my professors were consulting with all these spaces – and that's the other thing, the perception that disability is disability. So the thought was, okay, if this is how a hearing impaired trainee would do it, clearly a blind trainee would probably do it the same way. Which, no. If your left arm is cut off and my right leg is cut off, we're doing things slightly different.”
“So the accessibility piece. Gaining access and having things work. For example, the licensure exam has a component where everyone else can go in and sit and do a sample exam onsite and answer a hundred questions and get feedback. They have no means for me to do that. And so when I sat for the licensure exam there was no software, so there was no accessibility. So those types of things are still hurdles that really need to be cleared.”

“So in the hospital, you know, most hospitals are moving to electronic medical records. And our system was inaccessible.”

O10.7 Capes by finding system that works for her though means working longer hours?
“A Word document for each group interaction and then all of that is sent to our business administrator on the unit and then she scans every one of those documents into each patient’s chart. So it’s hugely laborious.”

O11 Disability has having impact on power dynamics between self and others

O11.1 Experiences uncertain/confusing power dynamics with colleagues and supervisees
“Everyone wants to be the good student. Or they’ll say, when I’m leaving the room, “Dr. […], your cane is over there.” Right? So there is that kind of change of dynamic and I notice I can come in with a peer, an equal peer, or a trainee, an extern who’s going to co-facilitate and the community will focus on [me] making sure that I am set up in a way, right? “No, no, Dr. […] always sits right there.” So they’ll protect my territory or whatever. And so sometimes I’m concerned about that dynamic.”

O11.2 Hyper-elevates students to contain own anxiety?
And so I find that what it causes me to do is, maybe hyper-elevate a student. Right? I keep emphasizing, this is my colleague, this is my colleague, when in all actuality, this is a trainee who’s under my supervision.”

O11.3 Shifts attention to supervisees to avoid attention on self
“Yeah, competent or – because it’s almost like a preferential attention is coming to me as the therapist.”

O11.4 Disability has having impact on power dynamics between self and others
“I observed how, I’ve observed how when I’m supervising, and I’ll have trainees or a trainee and the art therapist comes in and there isn’t that power differential, if you will. There isn’t the need for attention by, like the art therapist over the trainee. It’s kind of – there’s almost an equal playing field. But when I come into the room – and I’m not sure if it’s because I have the title Dr -- , or if my blindness. I’m not sure what it is.”
[Does she talk with supervisees about the power differential and how do they respond? Do they acknowledge their abelist privilege (assuming they are able-bodied)? What would it be like for Octavia to have a conversation with her supervisees about being blind? It seems like maybe this doesn’t happen due to her uncertainty about the dynamics.]

O12 Blindness adds positive value to therapy
“Now, there’s a positive component with patients and clients, because there’s something about the blindness that is an equalizer, right? So they, for whatever reason, may not feel as
exposed. Or they may feel more willing to open up because some things are just innately covered because I can't see them.”

“So, in that regard, that's the dynamic of the relationship, I think is changed by the blindness. I'm not sure – I question if it would develop in the same manner if I were not a blind therapist.”

“I think blindness causes me to be more patient sometimes because I’m going to wait and listen for it. Sometimes it allows me greater attunement, I believe.”

[Wait and listen for 'it'. The unconscious?]

O12.1 Recognizes that disability impacts how clients feel in her presence
Clients feel less judged/exposed

“She said, I love sitting with you. And I said, help me understand what it is that you love. And she said, you can't see me so you're not judging me and I feel like I'm more of a woman in your presence than in anyone else's.”

[A client who is othered (trans) feels more seen in the presence of a therapist who is othered (disabled).]

“And I had shared with you, sometimes I think it just provides a space for openness. Because people feel less exposed.”

O12.2 Clients’ projections about blindness allow for trust

In the end of our session – so we're probably at the 47 minute mark of 55 and he says, he says, ”I find it's really easy to trust you.” And I said I'm curious about that, help me understand what is it about me, what makes me more trust worthy? And he said, “I can't imagine what it's like to be blind and in a room with a big guy that everybody says is a criminal.” “And it's just you and me in here and I don't feel like you're paranoid or afraid of me at all.” “But you can't see me.” “You don't know what I'm doing.” So that blindness, allowed a space of trust.

[Client’s assumptions about therapist’s disability (whether true or not) may have a positive effect, especially if therapist does not correct client. Also, open challenging dialogue helps to establish trust between ay and her client as well as a discussion of being seen/not seen. She sees the real him.]

“So I actually expressed curiosity. ‘What would I have to be concerned about?’ And he said, ‘Well, as far as I know, nothing. But from everybody else’s perspective a whole hell of a lot.’ So that was powerful for me to recognize how the perception is even skewed.”

“As I shared with you earlier, when patients are agitated, for me I feel there’s something. I feel kind of the core of the agitation. So I’m not looking at the behavior.”

O12.3 Clients feel like she’s overcome/models hope

“Sometimes individuals connect with the fact that there's a brain injury or that something happened to me in my life, so that life alteration provides hope. Or people, clients will say – you've gotten over – you've gotten through.”

O12.4 Clients as nurturing

“Sometimes they want to nurture me and this particular client was in the session very much trying to gratify and appease me. Being hypercompliant and for me it brought about the experience of others.”
O12.5 Recognizes that she’s idealized, uses it in therapy process

“And so there was this kind of idealized role that I had stepped into just by virtue of being blind.”

[This is very different than someone embodying the super-crip/wounded warrior model as an image of oneself. Rather this experience of super-crip/wounded warrior has been projected on to her by patients. That she questions it suggests to me that she does not wear this idealized role lightly.]

“Yeah, on some days it is amazingly gratifying. And I have to be cautious because, you know, what am I getting from this? Because there are days where, yeah, thank you for validating me, confirming me. But my patients should not have to do that. Definitely should not have to do that. And then on other days, it can be – I can be challenged by it. And sometimes I use it… I use it to kind of reflect on maybe some familial dynamics where we’ve idealized something or someone. I’ve used myself as an I would never tell anyone that I couldn’t hear if I could avoid it. I would avoid it for the process.”

[Tension between desiring gratification and also realizing that it is problematic and that client’s shouldn’t have to gratify. Yet clients may gratify more than other people in therapist’s life? Disability as both a way of being and a tool in the therapeutic process.]

O12.6 Does not internalize rejection with respect to disability

“And this was some years after that. And when I shared that with him, he said, these are his words. “Oh, f-no, I can’t take another one.” And what I took from that was – yet another person with a troubling issue. I need to be – I need to be upfront and the most important individual in this. And for me to disclose my blindness it was like, wow. No more, I can’t take anymore. And so he and I discussed that. And he said it wasn’t about the blindness. He was just overwhelmed with all of the things that he had to deal with and so he would prefer to work with a therapist where there wouldn’t – he perceived that as maybe it was something else [experiences with Katerina] coming into the room. Beyond that no one else have ever – as a client.”

[She does not experience his rejection as personal or let it diminish her self-esteem – sign of therapeutic growth and acceptance of disability?]

O12.7 Countertransference around being cared for/given special attention

“And I found myself becoming aggravated and agitated as she was working to condone, comply, you know, appease me. She wanted to make me happy.”

[Similar to trainees, clients want to “nurture/gratify/appease” (e.g., patient who too readily agrees with O’s interpretations). But rather than hyper-elevating them, as with trainees, O. feels annoyed. She remembers her family doing the same.]

“I felt it within myself. My own growing resistance to her need to appease me. To nurture me. To coddle me. And she wasn’t doing it overtly. But she was kind of – as I would offer an interpretation, she was going with me far too readily.”

“And for me, I was angry about my blind – I felt it within myself.”

[She shifts here – is it hard for her to admit she may sometimes still be angry about being blind?]
“And I disclosed that I was aware of some feelings that were coming up in me and she kind of spoke to her mother having had blindness later in life and her mother being very directive and dictatorial and her need to please her mother. And then it made sense to me.”

“But I also recognized, almost like some semblance of projective identification. Somehow I had taken on this kind of role within myself, I had recognized something had been called out in me. [Octavia recognizes her own stuff – that it manifested in her taking on a role not unlike patient’s mother.]

“And I was angry. I went, please stop it, stop it, stop it, trying to appease me.” [Octavia gives patient a chance to respond differently, to have another experience with a blind person that is not what she had with her mother. Corrective experience?]

“She brought in a recording and the title of the song was Blind Mary. And she played it for me and cried. And I recognized my own kind of grappling with that. She said, “you have made such an impact on me that when I heard this song it made me cry. So I recorded it and I wanted you to hear it.” For me, I was wondering, ‘A’, the significance of the blindness. But also recognizing the significance of the relationship.”

**O12.8 Experiences patients as questioning blindness if she jokes too much about it — patients feel anxious?**

“And they’ll say, no “Dr. C., you’re not blind, you’re probably faking” – those kinds of things. Because if a patient is kind of continuing with the question, what is really going on with this cortical blindness. Those types of instances, they may question. Is she really blind? She keeps saying she’s blind. She walks with that cane. But I’m not sure. So in those instances, they can be — there’s a very fine line because, kind of, what really is happening in the room and how I respond to it.”

[When she tries to be funny with her patients, they react with seriousness and in turn make Octavia feel like she’s not seen. Octavia needs to be seen a certain way by patient (not too disabled) to support patient’s existing beliefs. Also experiences times when she can “pass” as sighted.]

**O13 Coping mechanism: controlling what she reveals?**

**O13.1 Use of disclosure to mitigate patient anxiety as well as her own?**

“So often I will speak to perception and how misperception is how we all kind of often end up in the hospital. Because either we’re misperceiving how we’re feeling or others. So I will say – so for me I am cortically blind and I’ll explain that. And then I explain, the reason I’m explaining this is because I wouldn’t want anyone to raise their hand in group, your arm would get really tired because I won’t ever see your hand in the air. And sometimes that will prompt questions. Often that will prompt questions and I will defer the questions. I’ll say, you know – I will acknowledge the questions but not in the group dynamic.”

[Her process of disclosure is different for group than individual – because group might be more likely to put focus on therapist. Better able to explore this reaction in individual therapy, perhaps. She self discloses and still stays in charge. Fits well with what you know of her so far.]
“In a private session, because there can be that resistance in group. The resistance is they’re going to put everything on the therapist and so if we explore the therapist we don’t have to explore ourselves. So, um. So. To avoid that I will throw it [self disclosure of disability] out there and let them know that at any other time we can certainly discuss any curiosities you have.”

[I wonder if there’s some anxiety for Octavia in terms of discussion blindness within the here-now of the group? Maybe she feels she might lose respect/power? Or is this about maintaining a boundary?]

O13.2 Ethics around self disclosure

“I find that on a lot of my lists, other professionals are very concerned about the perception of being deviant in not having disclosed. Like being deceptive in some way. And how fair is it to come and show up and you’re blind. Well, I show up and I’m black. You know? You can’t hear it on the phone. So yeah, I show up and I’m blind.”

“And for me I was angry about my blind – I felt it within myself”

O14. Interview dynamics: Here-and-now

O14.1 Uses here-and-now of interview to demonstrate meaning behind point

“So for example, you coming in here with me, you brought yourself into the room so you’re allowing yourself to really engage in this exchange. Sometimes we come into the process and we’re so caught up in – I don’t know – we don’t allow ourselves to be the instrument that the process can work through.”

O14.3 Difficult experiences addressed though hard to talk about as indicated by interruptions and pauses?

“The blindness piece was pretty significant in that I, I – ”
“— overcoming what it means to be blind was huge to me. I, I – ”
“oh, I’ve never had a therapist work with me who wasn’t whole. And I was stunned by that…”

O14.4 Difficult experiences remembered but not re-lived emotionally? Uses laughter to mask possible anxiety?

“And I cried and all that —(laughs).”
[Doesn’t linger here or elaborate. Not very effusive...professional, stoic. Maybe too painful? Or sees it as a simple fact of what it’s like to live as an oppressed person?]

“Most people think of blindness as the worst thing that could ever happen to anyone (jovial).”
[Mother said something similar too. Repetition of this statement leaves me wondering - is there a part of her that thinks that but feels the thought is inappropriate? She can’t think it or won’t survive but others can?]

O14.5 Similar experiences of taking in information: not back-white but continuum

“You know, I recognize you’re crying because I hear you sniffle or I hear the change in your voice. I’m not seeing the tears coming down your face. I: You see...but you can’t at the same time. M: My eyes see but my brain doesn’t tell me what my eyes see.”

O14.6 Feels it is important to highlight few rejections
“I had one person in all of my life who seemed to have a challenge with [my blindness].”

O14.7 Offers me advice/mentors when I don’t fully understand
“So disclosure, I certainly would assess the site before.”
“‘That’s the thing, if they don’t want you, did you want to be there anyway? If the hearing impairment is going to interrupt their desire to have you there, do you want to be there?’”

“My eyes are looking right at you, just like yours, but my brain doesn’t accurately interpret what I see. So it’s confusing for patients because I’m looking right at them. But I may not be able to take in the nonverbal information that — in the same way that everyone else would. You know, I recognize you’re crying because I hear you sniffle or I hear the change in your voice. I’m not seeing the tears coming down your face.”
[Speaks to supervisory role.]

O15. Experiences some isolation in community: may explain her drive for work?
“So. Sorta-kind of. Sorta. Um. (Laughs.) I belong to several list serves for blind and visually impaired mental health workers. The greater number of those individuals are — they come from social work. Um. And so their experience in some ways is very similar, but in other ways very different […] As far as psychologists, I’m aware of three other blind psychologists. I don’t know any of them personally or intimately. So. And as far as a community of individuals who look like me, if you will, I don’t have that. So. I-I-I [pause.]”
[Pauses/hesitations suggest she may feel conflicted/lonely?]

“I tend to go to my colleagues from school, or my cohort, or people from internship. None of whom are blind. So they still can’t speak to how to do it in the capacity of blindness.”
[Strong network outside of blindness.]

“I – I often – I often imagine what it would be like if everyone would sit in the room with their patients with their eyes closed. And how much more connected they might be?”
[She longs for connection/community with colleagues.]
Super-ordinate themes shown in **bold and underlined**
Working themes shown in **underline**
Working implicit themes shown in *italics*
Textual support cut and pasted from transcript
[Thoughts about theme in brackets]

**M1. Importance of time/experience on mitigating anxieties around disability**
“How I used to feel anxious about greeting a new client”
“feel anxious about finding a new shop”
“As time has passed and my experiences grown my disability has become far less of an issue than it was in the beginning”
“hence [don’t experience clients as being] as aware of my blindness as I might have thought they were as a beginning therapist”
“I worried that people would say outright that they didn’t want to work with me because I was blind. Now I guess through years of doing my own therapy I am far more comfortable.”
[Importance of time - shifting from an externalization of how blindness hinders/hurts/helps her work with a client to a more holistic, internal view, in which blindness is a part of her.]

**M2. Growth of identity as blind therapist**
“In the past I may have attributed my being blind to a specific piece of work that a client did or a comment they made….”
“My blindness is far more integrated into the way in which I work….”
“It’s like as I have become far more comfortable with my blindness as a result of doing my own therapy.”
“…got to see how others worked as therapists and then how I developed as a therapist working without sight.”

**M2.1 Aware of own strengths and limitations**
“I am not keen on doing group work because I think my blindness [is an] impediment in this environment.”
“[It’s important to have visual information on all group members [in order to] keep track of what’s going on in the group.”
“I think that whatever modality you work in you find ways around difficulties when they arise.”
“I did do some training in family therapy and found this a lot harder and took far more concentration to keep track of all family members.”

**M2.2 Does not personalize rejection**
“I have had clients contact my manager and ask to see a different therapist but I figure that this experience isn’t specific to me and there are multiple reasons for this. Often clients feel they need to shop around and see how different people work. Some clients are uncomfortable with the psychotherapeutic approach and prefer a more structured clinical psychology approach.”
“I will sometimes ask for clarification or try and deepen something and it will go nowhere
ie., the client will just close down and negate what I’m saying. This is all part of the process and they may not be ready to look at that specific thing which is ok.”

M2.3 Being aware of and working through own challenges
“I also think that having lead a life that has had a number of challenges in it due to being blind. I was quite acutely aware of the experience of feeling different, having to work harder to achieve my goals etc.”

Desire to achieve/go above and beyond?
“…aware of the high unemployment rate amongst the blind community so I was always aware of wanting to train in a specific field so that I could apply to do jobs within a specific field.”

M3. Therapeutic orientation as providing strong sense of therapist self
“I didn’t pick [Gestalt] specifically because I thought it would be the best way to work as a blind person”
[Suggests a focus on clinical skills rather than unique super-crip skills.]
“I also am part of a gestalt peer group supervision and we meet once a month to talk about our work from a gestalt perspective.”

M3.1 Relational approach allows for holistic connection with clients
 “[I am] open with my clients about my blindness and refer to my blindness in the first session.”
“I am often struck by how similar we all are as human beings in our need for a sense of belonging, to be understood, loved and accepted.”
“I really enjoy elaborating on and deepening experiences by the use of metaphor. My experience is that it often cuts to the guts of something and gives me a really accurate experience of my client’s inner world which them telling me a long involved story about something that has happened to them just doesn’t provide.”
“I guess it’s really important for people to not feel alone in the way they feel and also that feelings are not right or wrong they just are!”

M3.2 Acknowledges w/ clients impact of disability on therapy relationship
“The other thing that sometimes comes up is clients telling me that they saw me somewhere outside of the therapy room but weren’t sure what to do about that. We can then talk about how they would like to manage that in the future.”
“I do not want to feel I have put myself in the position of asking for help from a client in their place of work for example them ending up taking me around the super market or helping me out in a cafe. This would be really awkward for both of us.”

M3.3 Recognizes boundaries; doesn’t intrude excessively even if uncertain
“I think it’s important for my client to talk to me when he/she feels ready or maybe not at all.”

M4. Supportive work environment helps to create strong therapeutic self/identity
“Gestalt therapy was suggested to me as an option by my boss at the time who thought I would be suited to working in this modality.”
“Also my clinical supervision and more informal discussion with colleagues I work with in
the field.”

**M4.1 Treated as equal**
“I feel very respected by my colleagues in my workplace. Colleagues will come to me to
debrief or ask my opinion about something and I equally feel very comfortable going to
others for help or assistance when I need to.”
“I felt that my trainers were very accepting of my having a disability and were willing to learn
alongside me how I developed as a therapist. I really liked the way they honored my
experience of knowing myself and my prior experience of living with a disability so that idea
of me being an expert on myself.”

**M4.2 Shared responsibility for success at UCC**
“The area of my work I most struggle with is the technology side of it so at times I will go
to a colleague to ask them for help with doing something on the computer.”
“I feel that we work well together as a team being aware of each other’s strengths and
weaknesses.”
“I often ask one of my colleagues to check out a client for me so I have another person’s
opinion. I usually feel the need for this particularly when working with clients who have
eating disorders as I’m not always sure how accurate their view of their body is.”

[She experiences community and this community is built around shared experiences/skills
rather than disability. This might also explain why she doesn’t have/feel the need for a
community of other blind therapists. Maybe she feels her experience of blindness is less
outwardly radical/spoken? She seems to have had the best experience among all participants.
Wonder if this has something to do with the unique Gestalt orientation? Or cultural?]

**M4.3 Due to supportive work environment, is there less of a need for community of blind therapists? Lack of expressive language here makes it hard to tell.**
“I now have a few friends who are blind but wouldn’t say that I really have a blind
community as such.”
[Not sure about this but the sense I have is that she identifies first as a Gestalt practitioner,
and second as a blind individual? I don’t get that sense of loss that comes up in other
interviews.]

**M5. Challenges with disability occur outside therapy space**
“The attitude that I find most difficult in relation to my blindness is when people are
condescending or pitying, or both. This happens far more often outside the therapy room
and particularly with people in older generations to myself.”
“I have never however had a client tell me directly that they don’t want to work with me due
to my blindness.”

**M5.1 Disability isn’t primary focus in therapy**
“I am also aware of my clients being so focused on themselves and their own work.”
[It’s] not such a part of my client’s experience of me as their therapist…”
[Or maybe it is but they don’t communicate this to her?]

“There have probably been the odd time however that I have felt that a client pities me for
not being able to see. Thankfully this doesn’t happen very often though and I think this is
largely due to the younger generation being far more comfortable and more exposed in their
daily lives to people with disabilities.”
“I have plenty of counter-transference feelings when working with clients but I’m
struggling a bit to distinguish any that are in particular related to my blindness.”
“[I] don’t think that using metaphor is specifically related to my being blind”

**M6. Effectively uses disability in therapy space**

M6.1 Uses disability to psycho-educate/model:
“Clients often talk about struggling in a large group i.e. not knowing what to say or feeling
stupid for saying something silly etc. I will often talk about my own preference for talking
with people one on one or in a small group and how I also do not feel comfortable in large
groups but have developed some ways of coping with this when I need to be in such an
environment”

M6.2 To empathize
“[To] lead a life that has had a number of challenges in it due to being blind, I was quite
acutely aware of the experience of feeling different, having to work harder to achieve my
goals.”
“My experience of being blind has impacted on my decision to study and work in the field
of psychotherapy.”

M6.3 Challenges within psychotherapy dynamic around disability are workable
“[There are] times when I feel that being able to see my clients facial expression or
nonverbal language would be useful but this isn’t something that I constantly feel is missing
for me as I have adapted my practice and largely have other ways of managing these things.”
“[There are] occasions now when I feel that it would be useful to have a visual of my client
but I often ask one of my colleagues to check out a client for me so I have another person’s
opinion.”
[Why not ask client to describe?]

“Depending on where they are at in their course of therapy I might ask them how they feel
around my blindness. I would only do this if I had established a relationship with them
however.”

“If I feel that we haven’t yet formed much of a relationship I might answer quite briefly but
often as work deepens I might share something with a client that relates to what they are
talking about if I feel that it would be helpful for them in the work they are doing on
themselves.”

“I check in with clients as to what might be going on for them for example, if there is a long
silence. I might question them about how they feel about something if they are giving me a
very factual story and I’m not sure about their feeling state.”
[She brings forth space for client’s to discuss their reactions to her disability and she also
sets her boundaries by inquiring about workplace – especially due to the fact she can’t see
her patients from afar. A strong therapeutic relationship alleviates therapist’s concerns about
disability?]
M6.4 Uses client's projections in the service of furthering treatment
“I will often get people saying, ‘there are a lot of people far worse off than me,’ and I think they are directly referring to their realization that I am blind and they can see but at least once they have verbalised this feeling we can then work with it.”
“Ask what’s going on for [client] and get them to verbalise more their feelings etc.”

M6.5 Perceives clients as experiencing benefits of disability: to hide/not feel judged
“Often with clients who have an eating disorder they will say that they feel comfortable with me as they feel I won’t judge them on how they look. They like that I can’t see them and notice whether they have put on and taken weight off.”
“People often refer to feeling more comfortable due to my not being able to see them as they feel I won’t judge them in the way that others might do so.”

M6.6 Experiences negative responses around disability as indicative of lack of education or even diagnostic?
“Their responses to my blindness indicate that they relate quite differently to their peers. These people will come across as being quite clumsy and/or intrusive in how they ask me questions about my blindness. For example – how long have you been like that? or just walking over and patting my guide dog without asking first. I have also had the odd occasion where a client has brought another person into the session and hasn’t introduced them. I have sensed that there is somebody extra in the room and asked who is there.”

M6.7 Process of self-disclosure as straight-forward rather than overly inviting
“During the first session I talk a little bit about the way in which I work and as part of this I just mention that I am blind and let them know that as part of that I will sometimes ask them to elaborate on what is going on for them due to not being able to see their facial expression or nonverbal cues. I also introduce my guide dog and just let them know that he will remain lying on his bed throughout the sessions.”

M7. Minimization of Painful/Negative Memories
M7.1 Generalizes
“I guess we all have clients who particularly push our buttons and for me it’s clients who are very victim-like or the polar opposite of this which is people who are very privileged and entitled.”

M7.2 Doesn’t always expand
“I have had clients contact my manager and ask to see a different therapist.”
[What’s that like for her?]

M7.3 Works through countertransference reactions in private, away from session
“At times I will pick up on projective identification, projective or disowned aspects of the client which are felt by myself. I am learning to differentiate these from my own responses that may be counter-transferential and need to be bracketed and taken away to work on later in therapy or supervision.”
[Does she ever bring it into therapy sessions?]

“I struggle specifically with that attitude of them seeming to feel that they should just be able to have whatever they want in life with no real effort or sacrifice. I don’t think I feel jealous of them but I do feel irritated at times by their fairly narrow view of life.”
M8. Ambivalent feelings around interview questions
M8.1 Worry that answers are not right
“I’m not sure if I’m making sense to you here so please ask for more clarification if you need it.”
“I’m happy to elaborate or clarify anything that you don’t understand in my answers.”

M8.2 Exhausting for participant to use screen reader in way it is for deaf to lipread?
[Email might be harder because of exhaustion component in terms of having to record/use accessibility?]
Interpretive Phenomenological Analysis
Participant Themes with Excerpts from Transcript
“Nadine” (Face-to-Face)

Super-ordinate themes shown in **bold and underlined**
Working themes shown in **underline**
Working implicit themes shown in *italics*
Textual support cut and pasted from transcript
[Thoughts about theme in brackets]

Self & Self-Esteem

**N1. Possible effect of therapeutic orientation on self/world views**

**N1.1 Relationship between CBT and views on others/clients**

“And I’ve always had an interest in trying to figure out how people worked, you know? (Humor in voice.).
[“Figure out” sounds CBT-speak?]

“But the questions I ask and the sequence of the questions in doing an assessment, they say, ‘Wow, yeah, you really understand me.’ You know, because, you know, because the diagnostic criteria fits so well.”
[Relies on DSM rather than patient’s lived experiences. Yet clients say she understands them? Admittedly I find this surprising and want to disagree!]

**N1.2 Relationship between therapeutic orientation & views on impact of disability on therapy**

“I: Can you say any more about how being blind impacts relationships with clients specifically? Like process of therapy, the treatment goals?
N: It doesn’t really. It really does not. You know, if we’re working in a cognitive behavioral model, the student sets the goals.”

“I: You said you were also trained in psychoanalytic approaches, do you find that when you use a different way of understanding the client that being blind comes out more?
N: No, it really doesn’t. I mean other than, you know, I listen for it, but it doesn’t really happen – it doesn’t happen so often.”
[It’s almost like her therapeutic orientation protects her from having to go deeper, express vulnerability?]

**N1.3 Relationship between CBT and generalized views on disability**

“My experiences around oppression and then on the other hand, problem solving with regard to my disability have shaped the way that I work.”
“My disability is not going to interfere in any way with what they’re going to get.”
[“What they’re going to get — sounds very CBT speak and cut/dry. She controls situation?]

“I: You said you were also trained in psychoanalytic approaches, do you find that when you use a different way of understanding the client that being blind comes out more?
N: No, it really doesn’t […] Now, I do also work – and this is not traditional psychotherapy, but we have a program where…”

240
[She seems more engaged in non-traditional psychotherapy activities.]

**N2. Places value and importance on responsibility of self**

**N2.1 Students must fix own issues**
“Having the disability office, sometimes really, I think, compromises the abilities of our young people to really take ownership of their own problem solving around accommodations. They expect, you know? They expect that their accommodations are going to be made, and problems are going to be solved, you know?”
“…they don’t tell me what it is and they don’t tell me how to be helpful. They expect me to fix it, you know, and make the accommodation for them rather than coming with ideas as to what works for them.”

**N2.2 Takes responsibility for own difficulties**
“And so I really had to problem solve and advocate for myself and so that’s my spirit in teaching clients to advocate.”
[This likely derives from her own views on ADA/self-advocacy and life experiences?]

“On internship and practicum, really no issues at all. I went in initially, people knew I had the disability when I came in. And you know, I just talked to them and said here are the accommodations I need, and I talked about my role in problem solving, and this is what we can do. So it’s not that I expected them to make accommodations. It’s, here’s what I can do.”
[When she takes it on all herself, there’s no room for another person to experience what it’s like, there’s no room for vulnerability or for someone to try and make her life easier?]

**N3. Feelings of conflict: Being noticed vs. having needs met**
“We don’t see you as disabled. On one hand, that’s a compliment. But on the other hand, I want access to my materials. (Laughing.) And that’s a little annoying.”

**N3.1 Takes pride in others seeing her as successful/different?**
“My colleagues are pretty impressed by some of the things I pick up and they don’t…”
“I bet that person is rolling their eyes right now, and she said how did you know?”

**N4. Encountering conflicts between parts of self**
“I wasn’t expecting them to make accommodations because I wanted to come in with the problem solved already. Do you know what I’m saying?”
[ADA compromises ownership of disability and responsibility to problem solve. Will she seem weak if she expresses a need?]

“You know, I think the disability is not interfering anymore, or not affecting. Either that or maybe they want to be with [the dog].”
[Says disability doesn’t have an impact, but if clients want to see the dog, then disability is implicitly present and does have impact? Therapy might happen differently without dog present?]

**N4.1 Exploring disability with patient as anxiety provoking?**
“So I can actually tell when clients pick it up and play with it. Yeah, yeah.
I: Do you say something sometimes?
N: No, I just assume they’re a little anxious when they do that.”
[That she does not check with her patients about her observations speaks to her own confidence in situation. Does not use non-verbals in therapeutic process (from this example), yet she speaks so much about the use of non-verbals. Contradiction?]

**N4.2 Impact of disability seems confusing?**

“So earlier in your training, did you feel there were more instances in which being blind was affecting the therapy, positive or negative versus now?

I: Uh, no, not really. It’s – it’s, you know, it’s something that I pay attention to, that I integrate, and I’m attuned to. But really, I think, you know, honestly, because my population that I work with is restricted to college students, and I come from a very diverse campus, okay? So I work with very diverse students. Many of whom are marginalized themselves. I don’t experience that much. I really do not.”

**N4.3 Approval seeking?**

“So I said, here I’m going to color code and I’m going to do this – if it’s okay with you.”

**N5. Self-identity/esteem stems from presence of service dog**

**N5.1 Attributes clinical skills more to dog than to training/self**

“I: Why do you think they want to stay longer?

N: Um, I guess the relationship, you know. You know, I think the disability is not interfering anymore, or not affecting. Either that or maybe they want to be with [the dog].”

“When I have students that are depressed that come in, she gets one of her toys and puts it in their lap and sometimes she sits beside the client. Sits beside them, near the chair there that they sit in. So it’s really, you know, I think it’s really pretty straight forward and having that animal has been very helpful.”

[She says nothing here about her therapy skills as the reason why a client might return.]

**N5.2 Dog has special powers?**

“And you know, I’ve had a few clients who, I, um, I conceptualize as psychotic, and you know what she does? She has a bed under my desk and she doesn’t even go near them. She goes in her bed. And rolls up into a ball. She doesn’t interact with them.

I: So she can pick up on that?

N: Yeah, she can.”

[How does having the dog impact her views of self? Who does the guide dog really serve? Therapist or client?]

“So, you know, she’s actually – though she’s not trained as a therapy dog, she’s very intuitive.”

**N5.3 Dog as that which helps to establish rapport**

“I think it’s really pretty straight forward and having that animal has been very helpful [in establishing a] rapport with the client.”

**N5.4 Is noticed more for dog than for self?**

“You know, and sometimes some clients of my colleagues, you know, they’re seeing other people in the counseling center, they know I have a dog. And when they see my office door open, my colleague often bring their clients in so they can say hello to [the dog]. It’s very interesting.”
N5.5 Believes dog mitigates negative impact of being blind?
“You know, honestly, in terms of being a therapist, really not that many [challenges]. To some extent it may have to do with the fact that I have a service animal.”

N6. Minimization of painful/emotional memories
“There were no personal computers either and my electric typewriter wrote out my papers. It was not an easy time.”
“Experiences around oppression…”
“What you have to do is kind of separate yourself and try to understand the dynamic and that it’s not personal. I’m an object, I was an object to that person.”

N6.1 Deflects to other marginalized groups? Or finds connection with other marginalized groups?
“I: You notice they talk to you more than other people there?
N: Yeah, yeah, yeah, you know. Because the commonality is, they’re marginalized, I’m marginalized. And so, you know, they understand what oppression is and they understand what being marginalized is. And they get the fact that I understand it, too.”

N6.2 Rejects experience of being rejected?
“N, I expected you to be able to do 95 to 99 % -- well 90 to 95 percent of what your sighted classmates can do. You will never be able to be 100 percent in comparison to them because you can’t really see everything”. And you know in some way he was right, because I didn’t have the access to the labs, and you know, the methodology, data analysis because the technology wasn’t there.”
[Wonder if it this experience contributed to her now downplaying the complicated aspects of her disability?]
“Because it was very important for her to have somebody who was perfect. Physically perfect. Well, you know, it was okay. I know that it happens.”

N6.3 Doesn’t want to remember painful experiences?
“You know, I think the disability is not interfering anymore, or not affecting.”
[“Not interfering anymore” — did it interfere before? What was that like? What makes it hard to discuss past?]

N6.4 Does not allow internal feelings/emotions to develop?
“Okay, um. Let’s see. Countertransference reaction. Um. (8 second pause.) It’s really hard because they don’t happen to me very often. I really can’t think of any. I mean the closest one was this narcissistic client […] But you know, it really – before it had a chance to develop, I referred her out.”
[“They don’t happen to me very often” – as if it’s something external, outside of herself, rather than an internal process, which is how psychodynamic therapists experience CT. Her response here speaks to her therapeutic orientation.]
“I: Do you remember how you felt?
D: Well, you know, it was okay. I know that it happens. Especially if you think along the lines of psychodynamic kinds of things, you know. What you have to do is kind of separate yourself and try to understand the dynamic and that it’s not personal. I’m an object, I was an
object to that person.”
[Difficult experiences are singular and papered over or intellectualized. Was it really okay or has the feeling been buried? She is able to separate by seeing herself as an object.]

N6.5 Too much work for others if she expresses needs?
“They knew, I had been on practicum with them before. They knew me and they knew what they were getting in to.”

N7. Possible isolation: past and present
“Well, yes. I was the only visibly disabled student and trying to find readers, there was no disabled student program at that time.”
“There really aren’t that many [blind psychotherapists]. It’s very sad. There are not that many.”
“Very few students with disabilities at our university. Well, with sensory disabilities, actually.”
“You found a lot more blind therapists [for study]? Interesting.”
[Does she wish she knew other blind therapists? Lonely?]

Impact of Disability on Psychotherapy

N8. Disability has little place therapy room
Challenges as disabled therapist occur outside of therapy room
“…challenging to really work and do data analysis, and methods, and research methods, and that kind of thing.”

N8.1 Response to disability is perceived as diagnostic
“There was one person, and it happens mostly with Axis II narcissistic personality disorders, they literally said, I don’t believe I got a therapist with a visual impairment. That they got somebody that was flawed that way. Because they consider themselves as entitled.
I: So that they got someone that was flawed to them means —
N: Means that, um, that – that it’s an injury to them. Yeah, they only work with perfect people.”

N8.2 Doesn’t expand/inquire about client’s reactions to disability
“I: Do you say something sometimes?
N: No, I just assume they’re a little anxious when they do that [play with objects in her room].”

“I have had rare occasions where clients wanted to talk about the disability or wanted to talk about other things and it’s to distract, you know, it’s to distract from focusing on them, so I said, you know, really this is all about you. Let’s focus on you now.
I: So you tell them it’s a distraction?
N: Yeah. Yeah.
I: Rather than maybe engaging on that?
N: Yeah, I think — you know, it shouldn’t be a big part of the therapy.”

N8.3 Reassures clients
“You know, I answer them and I assure them that that’s not going to interfere, my disability is not going to interfere in any way with what they’re going to get.”
“I: If they do ask a question, how do you handle that?
N: Oh, I just answer them. Um, You know, I answer them and I assure them that that’s not going to interfere, my disability is not going to interfere in any way with what they’re going to get.”

N8.4 Doesn’t believe her disability really impacts students
“I: You talked a little bit about the client, the woman with the narcissistic style, do you feel that – can you say any more about how being blind impacts relationships with clients specifically? Like process of therapy, the treatment goals?
N: It doesn’t really. It really does not. You know, if we’re working in a cognitive behavioral model, the student sets the goals. They’re there for a specific purpose, that kind of thing.”
[When they inquire, she turns focus back on them….maybe she is afraid to explore disability with clients in therapy room?]

“Uh, no, not really. it’s something that I pay attention to, that I integrate, and I’m attuned to […] because college students as a whole tend to be very resilient and are pretty accepting of whatever they see or have to deal with more than maybe older clients. It doesn’t come up as much.”

“Many of whom are marginalized themselves. I don’t experience that much. I really do not. I think, um, because college students as a whole tend to be very resilient and are pretty accepting of whatever they see or have to deal with more than maybe older clients. It doesn’t come up as much.”

N8.5 Puts focus on clients rather than self
“And you know, really, the focus is about them.”

Minimizes conversations about disability/puts focus on client’s pathological disorder rather than opening up space for conversation??
“There was one person, and it happens mostly with Axis II narcissistic personality disorders, they literally said, I don’t believe I got a therapist with a visual impairment. That they got somebody that was flawed that way. Because they consider themselves as entitled. […] I: Can you tell me more, if you can recall, what happened when the person said it and the conversation you had?
N: There wasn’t much of one because we didn’t get past the issue. She immediately, when she walked in, she said, I don’t believe I got somebody with a disability, with a visual impairment. And we processed it a bit and it just wasn’t going to go anywhere. She was just very angry.”
[She outwardly states that her disability is not going to interfere – and then closes down relational dynamic and tells patients that asking about her disability is a distraction from their own work…what would it mean for her to talk about disability?]

“I: Does the client ask you more about [disability after self-disclosure]?
N: No, most clients are cool about it. You know, that’s fine. They want to focus on themselves. You know, it’s really about them.”
N9. Any experience of disability happens non-verbally
N9.1 Body as therapeutic tool
“Very attentive to looking in more detail at things that I may not be able to see. So I kind of try to pick up non-verbals in other ways” (Slight laugh).
“I can actually say to a colleague of mine, I bet that person is rolling their eyes right now, and she said how did you know?”
“I can also hear when clients are fidgeting or if they’re cracking their knuckles or things like that. So I can hear the movement kind of happening.”
[Maybe she’s so connected to the “non-verbal” aspects that it’s hard to verbalize her process of therapy? This is the only time she really acknowledges disability has having impact on therapy.]

N10. Uses self as role model for students/clients
“And so I really had to problem solve and advocate for myself and so that’s my spirit in teaching clients to advocate.”

N10.1 Disability as identity
“Because you know it’s part of – when we have a disability it’s part of our lives and how we think and how we process. And so, um, yes, absolutely, that it did.”

N10.2 Cares for students both in and out of therapy
“But there are a few students who are afraid of dogs and in that case I just give the dog to one of my colleagues or the receptionist or something. I don’t want to create an anxiety provoking situation for them.”

“So most of them are students of color. So there are other marginalized groups. So there’s a real connection there.”

“Because the commonality is, they’re marginalized, I’m marginalized. And so, you know, they understand what oppression is and they understand what being marginalized is. And they get the fact that I understand it, too.”
[Maybe this is a place where she can recognize how her disability impacts others (since it doesn’t seem to do so in the therapy)? Am I misinterpreting?]

N11 Esteemed View of Self: Wounded Warrior/Super Crip?
“So there are other marginalized groups. So there’s a real connection there. So you know, I’ve, um – the students have really developed. And it’s kind of a nonverbal connection. You know, students that are in gangs, tough guys, and things like that. And they somehow see a connection with me. And they talk, and they talk more to me than they would an able-bodied therapist […] And they get the fact that I understand it, too.”
[How does she know that these students talk to her more than they would an able-bodied therapist? Making assumptions about oppression and marginalization, as if all oppression is the same. She’s also not really speaking about her inner experiences.]

I: “…only been that one time [rejection by client]?
N: Yeah, really. It really has. (Jovial.) Yeah, I mean, my challenge is to have people not come back. They want to stay. They want more sessions. (Slight laugh.)
[What is that like for her? Overwhelming or a compliment?]
“On average our students stay four or five sessions, but I seem to get the ones that want to stay longer. (Slight laughter).”

N11.1 Feels need to prove self?
“So in fact, I really didn’t get the level of exposure that my classmates did back then. But I did enough to be able to finish. And now actually I have a career development award from [name elided] that is actually filling the gaps.”
“I wasn’t expecting them to make accommodations because I wanted to come in with the problem solved already. Do you know what I’m saying?”

Interview Process

N12. Ambiguity around doing interview
N12.1 Has difficulty going deep with question/staying on topic: Generalizes
“I: Can you give an example or a story?
N: Well, um, well. Well, it’s not necessarily one story. It’s more a theme.”

“I: So I presume you’re seeing a lot of Axis I type of conditions?
N: Correct. Yeah, yeah.”

“I: Why do you think they want to stay longer? […]
N: Um, I guess the relationship, you know. You know, I think the disability is not interfering anymore, or not affecting. Either that or maybe they want to be with the dog. You know, and sometimes some clients of my colleagues […]”

“I: Do you remember a specific time?
N: Oh gosh, it’s been like ten years ago. So I would process it really. You know, I would –
I: Process it?
N: Yeah.
I: Have there been times when you processed it and it hasn’t gone over well?
N: Yeah, yeah…”

“I: That’s interesting. I guess I would have thought the opposite given that clients wouldn’t have had a chance to maybe mature in the understanding differences?
N: Yeah, it’s um, it’s a pretty tolerant group.”
[Doesn’t seem to understand my question? Hoping she will expand, question my assumption. “Yeah” suggests she agrees with me but rest of sentence is in opposition of what I’m saying.]

N12.2 Interrupts to control?
“I: Given that you work from a cognitive model, I imagine that would make sense. I think some people that might be more psychodynamic—
N: Oh yeah, I could see that. I’ve done reading on that.”
[Wants to reassure me that she knows. Is she feeling anxious? Doesn’t seem interested in hearing my thoughts?]

“Can you tell me a little bit about your process of disclosure? Say I’m your client and I’m –”
N: Yes, oh yes. I always –”
N12.3 Does she really want to be doing this interview?
I: Do you do any group therapy or couples therapy?
N: No, not at this point.
I: In the past have you done some?
N: Yes.”

“I: Okay, we’re almost finished here.
N: Isn’t that amazing, yeah, think we’re going to do it, huh?”
[I think she’s referring to finishing the interview but unclear. She doesn’t really want to do this? Is it because of next panel she wants to go to? Thinking about space of interview and how it’s complicated our relational dynamic.]

N12.4 Difficulty answering questions target at psychodynamic processes
“I don’t experience that much. I really do not.”

“Okay, um. Let’s see. Countertransference reaction. Um. (8 second pause.) It’s really hard because they don’t happen to me very often. I really can’t think of any. I mean the closest one was this narcissistic client. I was quite surprised, um. And I really kind of watched out for any potential countertransference. But you know, it really — before it had a chance to develop, I referred her out.”

‘Especially if you think along the lines of psychodynamic kinds of things, you know. What you have to do is kind of separate yourself and try to understand the dynamic and that it’s not personal. I’m an object, I was an object to that person.
I: An object. So you were able to kind of not take that personally?
N: Uh-huh.”

“N: And I’m sure — you were trained psychoanalytically at least at some, right?
I: Yeah, I’m psychodynamic.
N: Okay. So listening for derivatives. So if somebody talks about, you know, gives derivatives about something having an imperfection or somebody not hearing somebody else, that kind of thing, I certainly listen for derivatives.”

“I: Derivatives so you mean the client —
N: The client’s stories. Yeah.”
[When Nadine doesn’t understand she shuts down? I’m left feeling confused? Is she experiencing my questions as confusing?]

“I: Help me understand.
N: When a client tells a story of, oh, you know my friend didn’t listen to me, you know, my friend didn’t hear me, you know, that kind of thing.
I: So you’re listening for —
N: Yeah, but also about imperfection.”
[Interrupts again – she seems uncertain and makes assumptions about what I know so she doesn’t have to finish thought or stay with it. She has difficulty staying with and fleshing out a thought…wonder if this is connected to interview dynamic/setup?]
N12.5 Frequent repetition of Yes/Yeah: Trying to convince me that all is always positive?
“I: What about in terms of, when you think about your supervision that you had in grad school and internship. Specifically, did you feel they were supportive?
N: Oh, yes. Oh, yes. Uh-huh.”

N12.6 Maybe seems overwhelmed by questions? Feeling anxious?
“Oh, my goodness, there are so many…” [When asked about problem-solving]

I: Can you say a bit about how your experiences in graduate school, internship, postdoc, have been impacted by your disability and the kind of support you got?
D: Yes, yes, I can tell you, um, the, um, the training director….”

N12.8 Interview process mimic’s N’s therapy style?
“I: If they do ask a question, how do you handle that?
N: Oh, I just answer them. Um, You know, I answer them and I assure them that that’s not going to interfere, my disability is not going to interfere in any way with what they’re going to get. And you know, really, the focus is about them. I have had rare occasions where clients wanted to talk about the disability or wanted to talk about other things and it’s to distract, you know, it’s to distract from focusing on them, so I said, you know, really this is all about you. Let’s focus on you now.”

N13. Role of non-verbals in interview
N13.1 Laughs when talking about successes?
“So I kind of try to pick up non-verbals in other ways. (Slight laugh).”
“I seem to get the ones that want to stay longer. (Slight laugh).”
“They want to stay. They want more sessions. (Slight laugh).”

N13.2 Laughs to cover up feelings of frustration?
“I want access to my materials. (Laughing). And that’s a little annoying. And that happens a little more often than, you know, yeah…”

N14. Interviewer’s need for repetition results in participant shutting down?
“I: So you let them know on the phone?
N: No, when I get them in the waiting room.
I: So they don’t know until you come in the waiting room?
I: So if I’m in the waiting room, you would come to me and say that in the waiting room? Or back in your office?”
Interpretive Phenomenological Analysis
Participant Themes with Excerpts from Transcript
“Grace” (Skype with Online Chat)

Super-ordinate themes shown in **bold and underlined**
Working themes shown in *underline*
Working implicit themes shown in *italics*
Textual support cut and pasted from transcript
[Thoughts about theme in brackets]

**G1. Challenges outside therapy space: Lack of accommodations/discrimination**
“We are required to record client sessions […] I was not able to not only not hear my own sessions but also the session of my cohort mates or supervisees […] so I was not able to give feedback.”

“We couldn’t even watch my sessions - I could not hear them.”

“It finally came to the permission of the Dean of the school to turn all these sensors off. These are his responses when the IT director brought it up to him: ‘Who the hell does she think she is? Those sensors cost us money,’ ‘Can’t we buy her new hearing aids?’, ‘Can’t we keep her in the basement in the clinic?’ and ‘What do we need to do to keep her quiet?’”

“Cameras fell down - broke shelf and almost injured client and myself.”

“iPod and iPad kept running out of space and did not record properly.”

“Apparently after thorough searches and lots of migraines - I found out they were interfering with my hearing aids.”
[Always seems to be something getting in the way of her accessibility?]

“No - in all of my internships, groups and individual clients - never had that kind of reaction from any client or group member. My issues and challenges have all been with the professors/staff/colleagues.”

**G1.1 Impacts therapeutic work/progress**
“Many times instead of talking about client issues I ended up talking about my lack of accommodations and all the feelings and frustrations I was dealing with and how that made me unable to function optimally.”

*Sarcasm as coping mechanism?*
“Let me tell you this is a boring clinic and those camera would have interfered with their somber decor.”

**G1.2 Ignorant remarks from colleagues seem to break her despite threat of lawsuit**
 “[My advisor told me they were] not used to disabled students at the PhD level.”

“The response was that - they can not do that because it is not AESTHETICALLY PLEASING to the room.”
“Oh well with the blind student we are able to see that she needs help - you are too functional.’ So it became a question of visible vs. invisible disability.”

“It should be the accommodations that get you through it should be your work just like everyone else - that’s how you did 2 Masters at [name elided] - they provided you with all those accommodations.”

“Yeah, finally I threatened to bring a lawsuit and they turned them off.”

G1.3 Few who understand outside of therapy space
“He turned out to be my hero - he not only listened and obliged but went above and beyond…”
[Those who do help are glorified?]

G1.4 Discrimination/challenges take a psychological toll
“At the end of the day – after all of my struggles and after ending up in the hospital after a year of struggles with accommodations and still not getting them – I have given up. I basically told my chair that I came here to do phd not to fight nonstop for accommodations and basically seriously considered leaving and transferring to another program or quitting.”

“After, the year I have had and the inability to gain accommodations for myself and literally ending up in the hospital trying – I gave up – what’s the point of doing a dissertation on that if I can’t even be successful in getting accommodations for myself?”
[Repetition of give up/given up emphasizes psychological struggle]

“I am very disheartened and discouraged and my experiences in the last year have broken me and defeated me and I could not handle my own experiences, forget about the ones of my participants too. It is too close to home so to speak and too much emotionally for me to handle while I am in this program and having the experiences that I am having.”
[This last sentence here might explain her need to focus on this for interview topic.]

G2. Challenges within therapy are few and far in between
G2.1 Lip-reading challenges
“There is this ego depletion or exhaustion if you will that I think all disabled individuals experience in trying to function in an abled body world – for me I feel like sometimes I am too tired to hear and do not have the strength or energy to try to hear anymore that day.”

Conflict around accepting challenges that exist in therapy?
“Lipreading does – everything does – just making sure I am in a position to always be able to lipread or hear and of course asking people to repeat 100 times a day.”
[But she said earlier that she never needs her patients to repeat? Contradictions? Initially there seems to be some denial around impact of disability but as conversation progresses it seems inevitable that disability has some impact — hard to accept challenges that exist w/in therapy session?]

G3. Therapist identity derives from multiple experiences of oppression
“Naturally dealing with multi-systemic oppression had influenced me to conceptualize in a systemic way and a feminist/multicultural way (multicultural needs to be a theory soon!) –
how has family, society, culture, neighborhood, history and so on influenced this individual.”

“I especially focus on the feminist multicultural to deal with oppression and meaning making (tiny existential there) and to support clients in dealing with issues.”

“My disability changed the way I saw individuals - the way I saw a diagnosis and a disorder and the way I saw human beings.”

G3.1 Disability as positively impacting therapeutic alliance

“It has helped me understand the "other point of view" I see every individual both abled and disabled both minority/majority as a multicultural being and also from a systemic view…”

“Thus coming from the disability view allowed me to see the client from their view as a minority due to gender or due to low SES or what their life is like due to trauma or divorce or whatever their issue may be. It made me willing and able to shift into their perspective and try to see it as they see it…”

G4. Wounded warrior: Clients see me as perfect, I see them as perfect?

“The irony of it all is that I have had more direct client hours than anyone.”

“There were a lot of meaningful moments centered around me ‘getting it’ or understanding it.”

“Well, let me tell you something – my clients – all of which are low SES and low level of education - had no issue with me being hearing impaired or disabled. When I had to conduct a session without hearing aids - they said not a problem and basically talked very loud and made sure I can read their lips […] they always offered to talk louder and I never had to tell any of them to repeat or speak clearly or uncover their mouth.”

“While I was freaking out and felt exasperated the client was fine with it and the session went smoothly.”

“That exhaustion from having to function in an abled-world and knowing what that is like has helped me with my disabled client tremendously - he thought it was just him and him not doing good enough - disclosing about me and my experiences and the experiences of others has helped him understand himself as a disabled person and how he copes and manages and how he sees himself.”

“I was trying to understand where she is coming from and what it is like from her perspective - her response was that I am the only one that is trying to see her for her and doesn't judge her or try to change her or tell her that all the things she is doing are wrong. She felt that I got her because rather than focus on her questionable behaviors I was trying to see why she was making those choices and what was the original root of her motives.”

[Given all the accommodation struggles she faces, it seems that disability within the therapy cannot have an impact or really be present because there are so many challenges she faces as soon as the hour is over. It’s as if the therapy hour is a time when disability doesn’t matter,
when her patients are the perfect clients.]

**G4.1 Self-discloses more than most? Function of demonstrating holistic therapeutic approach and background? To show multiple oppressions?**
“I tell them in the first session - I am a [country elided] immigrant disabled female that moved into the cornfields of [state elided] from [state elided] - I disclose all of it and assure clients that the fact that I am different from them is not going to be a hindrance but an asset to therapy.”

“In regards to the hearing impairment - I specifically tell them that sometimes I will ask them to repeat or talk louder and ask them if that will be ok with them. I also ask them to ask me any questions they wish and ask them how me being different makes them feel.”

“Why can’t the rest of the world be like this?”

**G4.2 Uses experience of disability in case conceptualization**
“Well it made me see a lot of characteristics that others may see as symptoms/criteria of a disorder I realize that they were not part of a disorder but rather as a coping mechanism in dealing with the everyday challenges of his disability. Also some of the maladaptive coping styles were merely survival tactics that he learned on his own.”

**G4.3 Takes care not to over-identify with patient’s disability**
“Sometimes with the disabled client I would assume he feels the same way I feel when he faces discrimination or prejudice or hardships - but I quickly learned that is not always the case and I stopped allowing my experiences to get in the picture.”

*Due to negative experiences with colleagues, does she unconsciously exaggerate positives with clients?*
“This is with all clients.”
“They did this without a second thought.”
“It was automatic for all of them.”
“They always offered to talk louder”
“I never had to”

**G5 Interview dynamics: Here-and-now**
**G5.1 Speed of typing/desire to stay on topic w/accommodations**
“I: That sounds so rough. And brings me to a related question that you’ve already spoken
G: this is on top of the 12-14 hr days I have with client, classes research, and all my other stuff
G: also
G: one last thing”

“Okay, now I’m done with that lovely tirade of incidents.”
[And then proceeds to discuss in last 1/3 of interview amazingness of clients. Polarity of interview flow mimics her real-world experiences.]

**G5.2 Desire to help/aware that I may have wanted different information**
“I am curious if your focus was more on clients reactions to disability in the therapy session?”
“I know I deviated a lot from that since my issues are not with the clients but with the accommodations and the people surrounding in acquiring those so I hope that I was still helpful!”

[I find myself wanting to make it better for Grace — what can she do going forward? Seek assistance? Threat of lawsuit did not improve things?]

Curious about my experiences? Have I struggled as much?
“I sincerely hope that your experiences have been better than mine!”

G5.1 Use of emoticons to empathize with interviewer experience
“Hey - though way you do not have to worry about transcribing or asking someone to transcribe :)

G5.2 Use of emotions/laughter to mask possible anxiety?
“G: I then decided to take matters into my own hand
G: :)”

“the system which he created from scratch did not work the first 10 times but worked the 11th time :)
[Interviewer responds with smiley]

“I went to the disability services, to the clinic director, to the clinic coordinator, the department chair and anyone else I could think of (laughs).”
Interpretive Phenomenological Analysis
Participant Themes with Excerpts from Transcript
“Anna” (Skype with Chat & ASL)

Super-ordinate themes shown in **bold and underlined**
Working themes shown in underline
Working implicit themes shown in *italics*
Textual support cut and pasted from transcript
[Thoughts about theme in brackets]

**A1. Challenges utilizing different therapy modalities**
“I do groups. But it’s very hard.”
“Because they [Axis II clientele] need a lot more. They need a lot more than what I can provide for them.”
[Sense of pride at having accomplished when there weren’t that many deaf PhD’s yet.]

**A2. Challenges with accents/client reactions**
“I’ve had a number of clients who have very thick accents who want to work with me and I was wishing they would find another therapist.”

“Underestimate my skills because of my hearing loss.”

**A3. Importance of time/experience on using disability in therapy process**
“Of course, the oddness of how to handle my hearing loss with hearing clients have definitely gotten better through the years. Going from wanting to ignore it, not talk about it. To now I am very open about my hearing loss.”

“I guess what I’m saying is, so the more I realize – the more open I am with my hearing loss, the less people underestimate me, and therefore they respect me. In fact, what I found is that when I don’t deal with my hearing loss it presents a lot more problems.”

“I have come full circle, treating it as a negative to now be okay with it.”

“I used to identify mostly with a deaf client when I first started therapy. Now, I try very hard to look at things more objectively.”

“So for example, I might excuse Axis II behavior saying it’s because of the deafness. And in actuality, it’s Axis II. It’s not about the deafness [...] On the other hand, if I have a client who is Axis I, yeah I’m more inclined to maybe identify with the client.”
[Rigid categories? Many patients don’t fit into these Axes?]

“Ever since I figured out that it was okay for me to address it, I’m okay.”

“I’ve always been more comfortable with deaf and hard of hearing clients, and I could identify countertransference, transference more easily. But with hearing clients, I would say I was much more nervous as a new therapist than I am now. But understand, I’ve been doing this for 25, 30 years. So, yeah.”
A3.1 Uses Client Reactions to Better Understand Clients’ Diagnostic Issues
“I have noticed – well, actually, if it is negative, I see that as being diagnostic.”
[Doesn’t internalize patient remarks.]

A3.2 One foot in both worlds: Isolation
“I realized I didn’t really fit in either the deaf or the hearing world.”

“But when I got my PhD, I think maybe there were twenty PhD’s across the country. Maybe. In fact, in [state elided] we only have – I can count the number of deaf psychologists on my hand out in [state elided].”

A3.3 Use of disability as metaphor
“For example, I used to strain to hear a client, a quiet client, thinking that it was only my problem hearing them and then realized that others also have a hard time with their quietness. So I use my heightened awareness to underscore the communication difficulty.”

“You know, I’m having a hard time hearing you and I’m wondering if other people in your life also have a hard time hearing you.’ And what I thought I would hear is, ‘no, not really.’ But in each case, they say, ‘Yeah, you’re right. People say that.’”

“The client I have remembers his father yelling at him all the time about raising his voice and he just resists. So for him, he was resistant to his father. So that’s a clinical psychodynamic aspect.”

“I used to hide my sign language and what I find is I sign with my hearing clients as well. And what I find is that they really like it. And the reason they like it is because it helps them understand how feelings are expressed.”

A3.4 Use of disability to model/psychoeducate
“So when I educate them, they’re okay. It’s when I don’t educate them that the anxiety goes up.”

“When I work with families, where there’s a deaf person in the family, I will use my experience growing up. But I’m very open about it.”

“My hope is that they can learn to see that their disability doesn’t have to define them; that they can see the glass as being half full rather than half empty.”

A3.5 Invites exploration from clients
“And then that opens up a way for exploring that more.”

“Constant clarification. Repetition. I work with them transferentially.”
[How? In what ways?]

A3.6 Brings self into therapy
“Another client I had was from another country and was very embarrassed about his speech. And I said, “Oh, I can relate.” So we talked about how that was related to low self esteem rather than just his speech.”
[Much of therapist identity connects to using disability in therapeutic processes?]

“I need to add that I used to be a dancer, so I’m very aware of body cues. So I use my skills and knowledge as well. I don’t call myself a body therapist. But I use body awareness as a big thing.”

“If I’m working with a couple, where one person is deaf and the other is not and I see one person treating the other one like she’s stupid, then I’m going to jump on that and say, ‘you know I’m a little uncomfortable with how you’re talking to your partner.’ So I will use that. Obviously I’m not going so say, ‘Hey, what you’re doing really sucks.’ But that would be the countertransference.”

A3.7 Feels clients appreciate unique listening skills
“I have been wonderfully rewarded over time. The years with clients being appreciative of that skill.”

A3.8 Scripted disclosure process to ensure consistency?
“I start every intake with a whole spiel of my hearing loss […] and it goes something like this. I say, ‘Hello. Before we get started let me tell you a bit about myself. I’m hard of hearing. And what that means is I do hear you some and I lip read you. And there may be times I might not understand you and there might be times you don’t understand me.”

A3.9 Emphasis on only one?
“I have to say, I’ve only had one client, one student say to me, I want to work with another therapist.”

A4. Interview Dynamics: Here-and-Now
A4.1 Very expressive, consistent with those in Deaf Culture
Takes phone call to demonstrate able-ness? Or to indicate that she doesn’t feel connected? Feeling of distance in interview?

A4.2 Desires to mentor me
“I: They help but it doesn’t make – like I can listen to music but I can’t understand the lyrics. A: Even when I was young, I couldn’t understand the lyrics. So don’t feel bad.”

“So that’s an example of transferential child. Somebody that’s had to grow up too fast.”

A4.3 Complications due to multiple modes of communication in single interview
“I: You can talk about whatever comes to mind. I’m not looking for any one thing. A: I think in a way it has been defined who I am. And harder to blame influence. My therapy (indistinct). I have come full circle, treating it as a negative to now be okay with it. I: Can you say more about that? Oh, you have a dog? A: (Our family has Sticklers syndrome spoken response.) I: Uh-huh. Okay. That makes sense. Okay. A: (Unspoken.) I: Okay. Can you tell me about a specific…(typing question).”
S1. Growth as therapist parallels with acceptance of disability

S1.2 Grappled in past with relationship to deaf identity
“I would never tell anyone that I couldn’t hear if I could avoid it, I would avoid it […]”
[Because she tried to avoid telling people she was deaf, she had to find other ways to communicate, to pass. This process, she feels, contributed to her development as a therapist, positively?]
“A challenge and a problem to be solved, rather than who I am.”
[Initially disability was seen outside of self…]
“But consciously, I wasn’t really dealing with, or I wasn’t paying attention to a deaf identity until later. Until basically, until the job search.”
[Challenges push her to confront disability?]
“I would say mostly [trying to pass] heightened my awareness of communication.”
[Positive benefit for therapy?]

S1.3 Doesn’t internalize objective remarks about disability
“like if someone tells me I can’t help them, I don’t personalize”
“so much about a disability is internalized and really it takes a while to separate from that and to recognize what are the true limitations”
[Seems like she’s worked through a lot of challenges to get to the place she is at now? She speaks with such wisdom; or maybe that is my projection?]

S1.4 Suggests she feels her experience of hearing is different than that of other deaf people? Or is she saying hearing people make these assumptions?
“And what other limitations because people who can’t hear, say they’re there.”

S1.5 Different but doesn’t feel singled out?
“I can’t hear at all, basically. But everyone in my life can. And so my family can. My husband can. My son can. My colleagues can. Um. Aside for, let’s see, an out-of-town friend, and a few acquaintances, everyone hears. So I feel embedded in that life, in this setting. I’m in a hearing world.”
“I mean, they tested me and told my mom I was a smart kid and I probably would be okay because of that. So at the time it was, you know, emphasize the cognitive and emphasize the abilities, nobody paid that much attention to emotional need.”
[Deaf child is left out emotionally due to emphasis of other needs (as valued by the hearing/mainstream community) — pursue psychotherapy to address this need?]
“Occasionally the clinic sees people who have physical disabilities. But no one with a physical disability has ever specifically requested to work with me.”
S2. Experiences some difficulties with disability; feels straightforward but not burdensome

S2.1 Lack of accommodations
“[Back then] there was no thought about accommodations [...] they could ask you about the disability. With the ADA they can’t exactly. So that’s what I mean for better or for worse [...] It became something that has to be more secretive, less out there and obvious. But there are still the protections.”

S2.2 Colleague perceptions about disability as challenge
“getting in the door” [with employment]
“both very difficult and both trying to shut their doors.”
“Can’t take communication for granted”
“When I was working I did my predoctoral internship at a VA Hospital and it’s hard to tell if it was about the hearing versus being a young girl with all these guys, all the Vets. But I think it’s fair to say that my hearing for them made me appear extra vulnerable, extra needing their care and attention. So sometimes it got in the way there.”

S2.3 Has to prove worth to colleagues for all to be “fine”?
“And I think in terms of my experience has always been once I am somewhere and my colleagues know me, I’m fine, they’re fine […] a lot of people, if they know in advance they don’t want to meet you, they just assume.”

S2.4 With client assumptions
[clients have assumed that I am] “literally not going to be able to understand them.”
“And so they may change their appointment before they even meet me.”
“I’m putting them out [narcissistic-oriented patients] by needing more from them in order to communicate.”
“I: Other people’s attitudes?
J: Yes. Always a barrier. Still a barrier.”

S2.5 With not hearing/lip-reading clients
“Some of them, let’s see. Accents. (Laugh) Accents are big.”
“structural stuff where there’s clients I still, no matter how hard I try, I just cannot hear.”
“They talk too softly”
“But then there are those that do. They mumble. They, um — let’s see, they talk too fast. They don’t pause. They don’t create opportunities for me to stop them and try to clarify things.
“who talk a lot and who talk fast, then too much of my energy has to go into getting what they say and there’s less opportunity for responsiveness”
“It’s automatic. There’s absolutely nothing you can do about it. (Slight laugh.) And it’s funny because most of the time the filling in that the brain does is accurate. Sometimes it’s not. But yeah. That happens a lot.”
[Less opportunity to delve deeper into psychodynamic processes/thinking and more focus on surface-level?]
S2.6 Not afraid to ask for repetition/clarification to clarify
“I sometimes ask people to write down a word if I’m stuck on it.”

S2.7 Clients w/ certain pathologies prove difficult
“or they’re depressed and their voices are way down and they’re not showing very much”
“entitled narcissistic vent, kind of approach the therapy like they — that it’s an imposition
on them to repeat things. Versus a hardship. Versus somebody who it’s hurtful to repeat. I”

S2.8 Laughter suggests mixed feelings about accepting difficulties?
There’s absolutely nothing you can do about it. (Slight laugh.)
Accents. (Laugh) Accents are big.”

S3. Impact of disability on psychotherapy processes perceived as grist for the mill, workable
S3.1 Recognizes limitations/boundaries as therapist
“And, um, there’s a handful who if the question was, do you miss a lot of what they say?
There would be some in that category, two, over the years. In a couple of those instances I
ended up referring them to somebody else. And in both of those situations I was worried
because the person was potentially suicidal. If there’s risk involved then I’ll tell myself, you
know, that’s not an okay situation to let things [not hearing every word] go”
“what are the true limitations and then because they’re there”
“I don’t do g…”

S3.2 Unique skills outweighed by difficulty of participation?
“I feel like I did observe more than my co-leader was able to because my co-leader was
attending to content. But in terms of carrying a group, it was not something I wanted to put
myself into.”

S3.3 Acceptance of Sophia’s difference creates a more introspective, even ableing therapeutic space
“Where I’m welcome to comment any way, they create more process, they create more
spaces. And then I feel it’s much less. I feel like I do say what I have to say. And I also feel
like I can come back to something if I think of something”
“So for me it’s much more about conversational style which takes two, than just me”
“Usually I can tell from their expression[…] So I’ll say, did I say the wrong thing or did I
miss something?”
“Basically I try to just talk with them about what they’re worried about.”
[Relational spaces are created differently when disability as acknowledged, even honored.
Communication as a circular dance that creates process and space for therapeutic contact?
Asking clients to repeat has the added benefit of getting them to slow down and become
aware of their internal processes.]
“If someone tells me I can’t understand them, I’ll think about that.”
[Difference between not hearing/not understanding—aware of this and listens for it in client remarks]

S3.4 Sympathy for patient’s difficulty but doesn’t put self down?
“Oh my goodness, they have to say it again. That would be — that I totally understand. That
does not evoke my reaction. That evokes my sympathy and my desire to help them do it in
as gentle way as possible”
“...They’re feeling kind of shy and that it’s hard to talk anyway and they’re worried about having to repeat themselves. They think it’s going to be painful. Which it is. It is going to be painful. It doesn’t mean it can’t be worth it.”
[Wonder how much of this statement derives from her own inner growth and experiences. If she spent so much time passing and not asking ppl to repeat, I wonder if doing so was also painful for her too. Lovely moment of insight too.]

S3.5 Awareness of difference strengthens therapeutic alliance
“And in many cases, it has strengthened things just because they know I’m trying. They know I’m really paying attention.”
“So I think they can feel that. They can feel my interest and attention and genuine desire to hear them and communicate with them and understand them.”

S3.6 Trusting that therapeutic process goes beyond hearing every word
“And yes, I let a lot of that go.”
“Have I missed anything they said? Almost all my clients would be in that category, I missed at least something
“If there’s no risk involved and the therapy seems to be benefitting them and I’m getting enough to help them, even though it’s not necessarily what it could be, or I’m not as responsive as I could be if I heard everything, um, I’ll still stay with it.”
“But if you were to ask me more impressionistically do you know what’s going on with the clients? Do you know what they talk about? Um, you know, all those kind of things, the answer is yes. Absolutely.
I: That makes sense.
S: But do you know exactly what they said? No.”
[This whole passage is a great example of the complications of disability and what it brings into the therapy. This hearing/not-hearing and how it comes in/out of the picture seems to be another thing in the room that the patient nor therapist can control. It’s there, and part of their work.]
“It’s very unusual for a client to say something only once, only one way. So sometimes just being patient, you know? It will come up again. You got another chance. They may use slightly different words the next time. They say it but it’s the same message. So that all helps.”
[Recognizing that client’s repeat things is part of her coping mechanism...and trusting in the therapy process.]

S3.7 Uses clients’ projections in therapy space
“When I ask them about it say more about what it’s based on, and it’s always based on something they assume about me.”
Some clients feel I’m going to understand them better because I’m going to know what it’s like to be left out. I’m going to know what it’s like to have hurdles. Um. Things to overcome. That kind of stuff. So some clients may feel it’s going to work for us.”
[Clients buy more into wounded warrior/supercrip than Sophia ? Noticed how she puts this on them, not her.]
“But you know it’s like, that’s okay with me. If it’s working for the therapy, they can assume what they want. (Laughing.) If it works against the therapy, I’ll clarify.”
S3.8 Client’s perceptions about disability can be interpreted as diagnostic
“Interestingly enough it’s not [the clients] for whom it’s realistic that feel that way. [For those
who are worried] it’s part of their clinical presentation — feeling isolated […] feeling
misunderstood”

“Clients who — let’s see, seem to be reacting. Um. The best answer I can give you is clients
who seem to be reacting. But when I try to ask them about it or talk to them about it, they
deny it. “No, it’s fine, no, no.”

S3.9 Does not ignore CT reactions in tx
“Clients with a kind of entitled narcissistic vent — that it’s an imposition on them to repeat
things […] that is a countertransference reaction to me. Yes, I feel annoyed and I feel less
motivated to help them. All that stuff. Something to work with. (Humor to voice.)”

S4. Uses but doesn’t exploit non-verbal skills to advantage
S4.1 Relies on non-verbal connections (almost as coping mechanism)
“Eye contact for me is almost constant.”
“Can’t take communication for granted. Let’s see. And because of that, I feel like I’m very
consciously present and listening and attending.”

S4.2 At the same time, non-verbal skills aren’t glorified/supercripped
“able to pick up a lot nonverbally but still would miss what they said”

Aware of skills but maybe they work better in individual therapy?
“I feel like I did observe more than my co-leader was able to because my co-leader was
attending to content”
“Some of those statements people make about, like, you can understand me better, or
something like that, ever rubbed me the wrong way? I would say no because they’re not
idealized. It’s not like they’re putting me way up here […] They’re somewhat reality based.”
[Maybe this connects to her ability to pass? Less glorification? Or is the UCC population less
likely to idealize?]

S5. Disclosure reduces anxiety for both Sophia and clients
“And another thing I learned is not to tell them right away. Not to start out with it. It creates
more anxiety than it stops.”
“The client has already had an interaction with me and is realizing that I am getting things
and so on and so forth. So they have a more realistic idea of, um, when I say that I don’t hear
well.”
“If I were to tell them in the beginning, it’s their image of what that’s going to mean”
[Which might impact Sophia ‘s ability to stay present in session?]

S5.1 Waiting also seems to lead to more positive responses from clients?
“Most of my patients say, you know, they’ll say something that’s just, ‘That’s fine, that’s okay.’
[…] A rare response is that, Um. ‘That could be good for me, I should probably slow down
anyway.’ Let’s see. A not rare, but less common response is, ‘Is there anything I should be
doing differently?’ ‘Should I talk louder?’

S6. Support from supervisors contributed to self-confidence
“Treating me as a very capable person who was going to have some challenges that they
were excited to help me figure out.”

262
“really wonderful um, and all of my supervisors are hearing, but they all seem to get, and care about the situation I was in”
“So what could be done was my supervisors trying to tell their colleagues, you know, wait a minute. She can do the job. She was fine here. Give her a chance.”
“Very helpful supervisors.”
[Helpful supervisors/positive grad school experience is also what allowed Sophia to see disability “as a problem to be solved” rather than ongoing identity??}

S7. Desires to connect with interviewer
S7.1 Reassures interviewer that all will be fine
“And it’s having— it will get easier with age and experience. It will. Honestly.”
[“Honestly” — interesting emphasis?]

S7.2 Reassures interviewer that she hasn’t had trouble keeping clients
“For those that stayed with me. And that’s most patients, um, most patients will stay with me”

S7.3 Empathizes with difficulty connecting to Deaf Culture/Sees Self in interviewer
“J: But I stopped using sign language when I was seven and then just went to speech therapy and talking and now I’m trying to learn it again.
I: It’s definitely hard. I: I feel like the ability to master new language is part of it, too. It’s kind of amazing how much you forget, you know, when you’re not using it.
J: Absolutely. Yes.”

“J: The conversations that don’t go well is those who say, well never mind, or I don’t know, or I forgot.
I: Or maybe they change what they said. I get that sometimes.
J: Uh-huh.”

“I: But in the session it’s like this intensity that I feel like sometimes takes away from me a different level of, I don’t know, thinking or — I’m not sure if that makes sense?
J: It does. It does make sense. I experience it as tiring, definitely. It’s pretty exhausting actually.”
Interpretive Phenomenological Analysis
Participant Themes with Excerpts from Transcript
“Alex” (Face-to-Face)

Super-ordinate themes shown in **bold and underlined**
Working themes shown in **underline**
Working implicit themes shown in *italics*
Textual support cut and pasted from transcript
[Thoughts about theme in brackets]

**AL1. Curiosity about self/other experiences**
“I wonder how many people that are blind or visually impaired cannot get through a program or don’t apply for a program or aren’t accepted for a program because I can’t ethically or validly reliably administer a WAIS.”

**AL1.2 Aware of privilege/place in life**
“I have all kinds of privileges as an individual with a disability […] given that I’m a professional, I have great benefits and great privileges that most of my [blind] peers don’t have.”
[How does he understand this privilege? Use it? His experiences have added up, somehow, to make him thoughtful, self-reflective – just enough hardships but also enough positive moments and supports?]

“So I was fortunate in that it could have spread. I could have died. They could have not diagnosed it. It could have been more severe consequences.”

**AL1.3 Confusion around passing as sighted**
“So what does that mean? I have a cane and I’m a man, 6’ 4”. I’m not, like, invisible so why is it that they can hit me?”
[Anger?]

**AL1.4 Curious world-view**
“I cross streets where people say that I’m not really blind and faking it. I’m not really being — I’m lying essentially about who I am and the fact that I have a visual disability. I’ve heard people yell out the window also at me that he’s not really blind, he’s faking it.”
[He doesn’t seem angry as he tells me this, maybe incredulous?]

“All or nothing. It’s not a continuum. They don’t understand it as a continuum.”
[Important for able-bodied people to see blindness as all/nothing; otherwise they feel threatened?]

“People know what it means to be sighted and people know what it means to be totally blind because they can close their eyes and imagine what it is. But they don’t know what it means to be partially sighted.”

**AL2. Therapist identity connects to identity as blind man**
**AL2.1 Reflects on accepting blindness**
“It’s an identity of having visual disability is very – it’s an odd place to be.”
“I didn’t want my disability to be such a prevalent part of my identity in defining me in what I could and couldn’t do, although it did. Um. Uh. Even though I didn’t want to admit it.”
[Sounds wistful, almost proud. Speaking from a place of real self-reflection, learning…]

“And there’s a bit of a coming out process, quite honestly. Accepting and embracing my disability.”

“I’ve become maybe less tolerant of stuff over time (laughing) and just being more direct and to the point of things.”

“Maybe just because I wanted to be out there, I didn’t want to feel like I was hiding anything or not disclosing. And again, letting people decide. This is who I am, take me or leave me. This is what it is.”

“I mean I’m actually more transparent now than I used to be, just about myself and who I am. Pretty good about the disability because it’s not something that I can hide.”

“You know, going into the doctoral program actually because there was such an emphasis on multicultural – a greater emphasis on greater multiculturalism living in a pluralistic society.”
[Emphasis on multiculturalism in doctoral program helped Alex come to accept his disability, even to embrace.]

“I think a lot of the factors [as to why I went into psychotherapy] had to do with the reality of my disability.”

AL2.2 Reflects on growth as therapist
“ I do put myself out as somebody that works with physical disabilities and I specifically highlight that”
[That he desires to reach out and treat those identifying with PD suggests he is comfortable and open with his own disability. Owns it comfortably.]

“I use a variety of different theories including cognitive, cognitive behavioral, insight oriented, persons centered, and interpersonal process types of theories. That conglomerate aspects of that seem to work most effectively for me in working with the population that I serve both in the university and then in my private practice, as well.”
[Integrative orientation with relational undercurrent derives from lifelong desire to connect, understand, which may result from longstanding experiences with coping with challenges. Flexible orientation – does this come out of a history of being disabled and needing to adapt? Does orientation correspond somehow with experience of disability?]

“I think there’s a diversity, multicultural component to that, as well, that doesn’t necessarily have it’s own kind of specific domain but it’s rolled in throughout the whole approach as well.”
[Like with a disability, it’s hard to separate specific aspects of MC diversity that may be at play in the here-now.]

“Theoretically, I never resonated with the analytic framework.”
“I think [now] I might have been more assertive with him in talking about [reactions to blindness] and just what that meant and try to process how he felt more about me and working with me…”

“It’s all rolled into one, although I’m still learning about that.”
[Not afraid to express that he doesn’t know everything.]

“Again with people that really invested in my growth and development. And that also includes clients that have challenged me to grow in my growth and development. And just opportunities to expand myself as a professional”
[Recognizes role of clients in challenging and helping him grow – desires to learn from other. Learning is a two way street.]

AL2.3 Derives meaning from finding career that fits his true self
“The disability did have a variable in the sense that, um, while I enjoyed the work and what I was doing, it was a very isolative environment and just pretty lonely. And working by myself and not having the flexibility, because I can’t drive, that created just greater – sense of isolation and recognition of that, as well […] So I think it actually did help [with my self-esteem], you know, going into the doctoral program actually because there was such an emphasis on multicultural – a greater emphasis on greater multiculturalism living in a pluralistic society”

“I enjoy probably recognizing that I could have maybe benefitted from some psychological services when I was a child that really weren’t available, or my family didn’t access, and just the realities of the disability and. So I think that had a factor in it as well.”

AL2.4 Learns from past experiences
“I probably would have done it differently now than I did then, but I tried to be very real with who I was […] and also coming to a greater integration of who I was and that’s an ongoing process…”

AL2.5 Mixed support during graduate results in greater self-advocacy/understanding of self
“Working with faculty that were challenging, encouraging, and supportive. And really invested themselves in my growth and development as a professional.”
[Supportive environment begins early on in graduate school = time for social confidence to grow and develop.]

[“I felt discriminated against [during TA interview position] because I had a disability.”

“That was still a relatively new domain and I did feel discriminated against in terms of graduate assistantships.”

“He was totally blind. And that was one of the reasons I ranked the place to actually go there for internship.”

“I did get a lot of support in that way by having extra time and some resources.”

“I felt there was some level of lack of opportunity for me.”
“So actually that process felt discriminatory to me as well because I know they had resources. And then it was somehow, another counselor contacted me out of the blue from the agency [...] And she really stepped up to bat for me.”

[Therapeutic orientation and development shaped by interactions with challenging and supportive professors, by working with “excellent supervisors” in a variety of settings, by having people personally invested in his growth (including clients), and by expanding self as a professional.]

AL2.6 Experiments with disclosure styles following relationship with blind mentor

“So again there was communication without him needing to necessarily disclose it. So people may have picked up on it right away. Which, again, is similar and different than what I did. So then I kind of swung the other way and didn’t [explicitly] self-disclose for a while. And then I don’t know why I swung back the other way. Maybe just because I wanted to be out there, I didn’t want to feel like I was hiding anything or not disclosing.”

[Relationship with blind superior changed own relationship to disability in therapy. Maybe A. felt pressured to change? To please? Or maybe just interested in exploring other ways to disclose?]

“I’ve gone through different stages where initially I thought I needed to talk about it. And then there was a period of time when I didn’t talk about it at the beginning of meeting somebody. And now I just lay it out there at the beginning and I give a couple sentences, a brief self-disclosure about it.”

[Trying out different methods seems like an important part of his development as a therapist and acceptance of disability?]

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AL3. Disability brings something positive to the therapy space
AL3.1 Allows clients to feel seen/heard

“So I think there’s power in that. I think there’s times when people are going through hard times themselves and it may be something completely different than a physical disability issue, but, um, they, I think it can be therapeutically beneficial to them to know that I do understand what it means to be different. And I do know and understand what it means to be discriminated against. And I do understand an aspect of what it means to hurt or those types of things or feel alone or feel those types of emotions.”

“And I think just having her [patient losing sight] be able to tell her story to somebody that can at least relate to some aspects of what she had went through, I think, was really powerful for her and just the self-acceptance […] And yet she was very depressed and thought about suicide and things that she didn’t necessarily talk about with people in her life but was willing to share and be open with me.”

[Shared experiences impact alliance.]

AL3.2 Childhood desire to fit in helps him understand client experiences

“I wanted to feel like I belonged to the mainstream of society and not being different.”

“an inherent appreciation for people that either experience different life experiences and maybe experiencing some level of emotional pain in their life.”
AL3.3 Focus on internal process rather than superficial
“…a positive thing. In the sense that maybe they don’t feel like I’m judging them or looking at who they are in that much detail. That I’m looking, maybe or experiencing them more internally about what they’re talking to versus externally where they might be talking more about their feelings, so really connecting more with that versus outwardly appearance.”

AL3.4 Reduces power dynamics
“And I think they [patients in mental health hospital] recognized, again, that I appreciated who they were. I treated them like people. They didn’t feel, like, different or inferior or something just because maybe they were lower SES or different ethnicity than I was. I think maybe they were able to connect with me and I with them at a different level just as a positive benefit of having the disability.”

AL3.5 Subtle yet powerful validation of client’s feelings
“I think I’ve asked a client, it seems like you may want to cry or need to cry and give that invitation, but I don’t necessarily ask for clarification, are you crying or not crying? I open the door to try to create a safe place for them to cry if they want to. And validate and normalize that it is okay.”

AL4. Reflects on/works with client projections
AL4.1 Questions wounded warrior/supercrip phenomena
“A: The hero complex of, oh, you’ve done so much.
I: The wounded hero complex?
A: Yeah, like, wow you’ve overcome so much. You’ve not let your challenges defeat you or be a barrier to your —
I: Do you have feelings about that when they say that in session?
A: Uh. I just kind of let it go and let it go in one ear and out the other just because I understand that that’s how a lot of people react to individuals. You know, that seems like they — and there’s probably some truth to it.”
[Recognizes how patients elevate him but does not get a big ego; does not buy into wounded warrior phenomena.]

AL4.2 Uses the here-now of relationship and what’s in front of him rather than buying into special nonverbal powers given disability?
“You know, I think that maybe some fluctuation in vocal tones I might pick up differently than other people. But I don’t know how to compare that.”

“Um. I think there’s some inaccurate stereotypes, I think, are on that. Sometimes I think my clients may think I can’t see but I can hear better than other people. Or I listen more effectively, and I don’t necessarily agree with that […] listening is, uh, something that is a communication style, it doesn’t have anything to do with if I can see or not.”

“Because I think listening is, uh, something that is a communication style, it doesn’t have anything to do with if I can see or not. I think anybody can develop strong listening and communication skills. Um. And it doesn’t just have to do with, like, having a disability.”
AL5. In touch with own counter-transference reactions as they relate to disability
AL5.1 Longing for desire to drive and read
“Or used drugs and drive. And I kind of get pissed at them. Not only because I don’t tolerate that, endangering other people. I don’t have any judgments, if people want to drink they can drink as much as they want, whatever they want. It’s when it crosses the line into putting other people at danger I’ll be pretty confrontative about that. But I’m not cool with that. That that’s not cool. So there may be something else behind that in terms of, well, I can’t drive. I wish I could drive and here you are able to drive and you’re driving really stupidly by being drunk and driving and putting yourself and everybody else at risk. So there might be kind of in that type of situation.”

“And they may carry over into other economic stuff. Even with advanced technology, it’s not easy to read for me or I read a lot slower than other people and when people aren’t even trying or they don’t even read the book or buy the book and not using their education as much as they could, maybe that sense of countertransference or maybe jealousy on my part. I wish I had what they had, it would have made my life a lot easier than it was in terms of doing a degree and stuff like that.”

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AL6. Feels sense of loss for denied opportunities
“To be rejected in that manner and not even be given a chance essentially.”
[Self acceptance allows for vulnerability, admittance of painful feelings, in this interview moment.]

“Just not feeling I got certain opportunities that other people might have had if they didn’t have a disability.”
[Does not seem to hold a grudge.]

“Discrimination. I mean, I think there was that sense of feeling”

“I felt that just in job interviews too at different points […] and it affected me as a therapist.”

“And I honestly don’t remember ever knowing what it meant to see out of two eyes. My memories — while I do have memories of that experience of being diagnosed and things like that, I can actually remember going to doctors and all of that. Um. I don’t remember what it was like to see out of two eyes so I don’t know when it actually…”
[Sense of loss?]

AL7. Feelings of isolation/loneliness
“Kind of. I have an online presence with some list-serves that I’m on.”
[Vague? Non committal?]

“But I mostly lurk more, honestly, on those as opposed to contributing on those. I like to see what people are talking about on that field. So I don’t contribute a lot necessarily.”
[Takes a backseat role after prior involvement ended in disappointment?]

“But I don’t have any other people that I regularly communicate with that have a disability.”
“It feels lonely. I’ll be honest. Even in the profession, even in the realm of [city elided], the one psychologist that was blind working at the [agency elided], he moved away somewhere else in the state. I don’t even know any other individuals that have physical disabilities of any type that I would have immediate access to or could relate to. I would say there’s definitely a loneliness in the profession. I would say that’s true.”

[Repetition serves to emphasize his point.]

“But even since then it’s not easy to find other people with disabilities. Before I was even on the committee, I asked to be paired with a mentor. So I learned about the mentoring program through CDIP and I was paired with a mentor. But really the mentor wasn’t available, didn’t respond. So I kind of gave up on it.”

[Attempts to connect failed; wonder if he might like to know about other participants?]

“Occasionally, definitely still some folks from CDIP that I interact with by e-mail or telephone call. Not often.”

“Sometimes the students or whoever I was connected with, kind of disappeared.”

“That was one of the things we tried to work on when I was on the committee, is accessibility of assessment instruments and we got some real push back in the profession from other psychologists that didn’t want to see those tests altered in any way. So I didn’t feel real supported even by the profession.”

**AL8. Laughter as covering up memory of painful feelings? Or to avoid reliving painful experience?**

“They said they wouldn’t help me (laughing) because I had gotten an undergraduate degree or whatever.”

“And they [APA committee] wouldn’t provide [the assessment tests] in accessible format, because god forbid, I’d be on eBay selling them all (laughing).”

And actually, after the interview I felt so unsettled about it that I did go back and confront, or talk to that person about it. Now that being said, they would never admit (laughing) if they did, that was a lawsuit waiting to happen

“But the first session [autistic client] came in he had — again the mannerisms of that — he waved his hand right in front of me, he stood up and waved, can you see me? (Laughing.) You know?”

“Well, the first couple years I was there they said they couldn’t do anything for me. They said they wouldn’t help me (laughing) because I had gotten an undergraduate degree or whatever.”

**AL8.1 Recognizes some limitations are due to ignorant views of others**

Difficulty with assessment testing is largely to how others perceive blindness (see end of interview where he talks more about this!)

**AL8.2 Has overcome**

“Quite honestly I worked very hard for [his position as director].

**AL8.3 Recognizes but isn’t bogged down by limitations?**

I can’t do a Rorschach the way it’s structured right now. I mean I can have somebody go
complete an MMPI on a computer or something but I don’t even do that. That’s not something we do, or I do in my profession.”
“So, like, if I sense someone is sad, I may name it. But I’m not able to tell necessarily that they’re crying, you know, if they reach for a tissue or if I hear them cry. But if someone slightly tears up I can’t really zone in on that like if I had 20/20 vision.”

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AL9. Self-Advocates
“own advocate”
“After the interview [where he was discriminated] I felt so unsettled about it that I did go back and confront […] they would never admit (laughing) if they did, that was a lawsuit waiting to happen. I did it for me.”

“People can accept me if they want to. Or not accept me. But if they’re going to accept me I want them to know kind of the whole package of who I am. And not just pick and choose parts of me. Um. So I think there was that.”

“Again, I have to be my advocate more so than just people naturally making things fully accessible.”

AL10. Positive outlook despite setbacks
“I: Did you get a position in the end?
A: No, I actually worked outside of the university and I got – I actually worked full-time through my graduate program at the mental health group home that I mentioned. And then I had another small part-time job that I got, as well.
I: That’s intense.
A: Yeah, it was. But I’m glad I did it.”
[Positive outlook...does this serve as a coping mechanism?]

AL11. Doesn’t want to inconvenience others by putting needs first
“And so now that I’m the director, am I going to spend a lot of money on myself to get accommodations, way out of our own budget? Well, no, I’m not going to do that. That would feel really uncomfortable to me in terms of my other staff.”
[He has worked hard for what he’s gotten and in turn is well-respected, although university does not have a central DSS office. Feels guilty if he uses UCC funds for his own accommodations rather than general counseling center needs. Would also make him feel uncomfortable. Desire to put needs of others before his own? To benefit many rather than just himself? Tension between self/other needs? Does this contribute to loneliness?]
AL11.2 Desires to help interviewer/be good interviewee
“I don’t know if there’s things I’ve not responded to that could help you in your dissertation and this research that you’re trying to create for yourself.”
“It was very comfortable and I appreciate you coming over to do it with me. I hope things I shared can be helpful for you.”

AL11.3 When I ask for repetition, be not only repeats but goes deeper
Uh, but again I lost all the sight in my left eye, it’s a prosthesis and most of the sight in my right eye.
I: After the age of two-and-a-half.
A: Yeah. So I was fortunate in that it could have spread. I could have died. They could have not diagnosed it. It could have been more severe consequences.
I: So this is after the age of 2.5 that you gradually lost most of your sight?
A: No. I mean it was, my eyesight changed over time but it was because of a cataract, the radiation and the things I had been exposed to.
Interpretive Phenomenological Analysis
Participant Themes with Excerpts from Transcript
“Jaime” (Face-to-Face)

Super-ordinate themes shown in bold and underlined
Working themes shown in underline
Working implicit themes shown in italics
Textual support cut and pasted from transcript
[Thoughts about theme in brackets]

J1. Influence of childhood experiences
J1.1 Influence of childhood experience on therapist identity
“But also, I grew up in a home that was – had an [abusive caregiver], the worse verbal abuse. So, um, I had a stepfather who told me if I ever told the cops that he would just say he was crazy, and he would laugh, and they would let him out. In the old days they didn’t have rules for domestic violence and all that stuff. So unconsciously, somehow it led me into being a therapist.”
“And anyway, so my [family member] committed suicide when we were 19. So that aided, another wanted me to get into the therapy field.”
“And I think after a while my own therapy subconsciously or unconsciously, all the stuff that I grew up with, with my stepfather saying if he got caught he’d just say he was crazy and they would let him go. But not for me, lock you up and throw away the key, I’ll call the cops, too. Like the therapist that gives you that kind of power where appropriate. And then my [family member] killed himself. So that’s how I got into psychotherapy. (Laughing.) That’s a long way.”
[Becoming a therapist was maybe both a coping mechanism and a way to make sense of the early abuse and trauma in her life.]

J1.2 Influence of childhood trauma on early clientele population?
“When working with traumatized, trauma – especially abused, domestic violence, you’ll get borderline personalities and I worked a lot with them. I worked too many. So I try to balance the high-functioning ones.”
“But most of my career I worked with trauma.”

J1.3 Desires to protect/take care of
“That way I could protect the kids.”

J1.4 Believed in self before receiving negative comments about being Deaf
“That was a terrible thing to say [about deafness] and frightened me because I had been all-American [sports team]. There was nothing that I could not do.”

J1.5 By hearing people who decided how it would be
“And they said you need to be with your people.”
“They put an interpreter in my class.”
“They told me I had to major in deaf-ed.”
“We will give you your degree but you can only teach deaf.”
J.6 Initial experience of Deaf Culture resulted in ongoing psychological trauma
“Because the only deaf people I knew were homeless, handing out ABC’s on the corner, I just freaked. So I went into a depression.”
“My people? What do you mean? Deaf? I had no clue what deaf is. It was like culture shock.”
“I can hear the teacher a little bit and I’d look at the interpreter and know a little bit. I was lost. I was lost.”
[Wonder if her experience of living in a world of confusion makes her a better therapist? In the interview she presents as not lost or confused but very certain and confident, even if she goes off on tangents.]

J.7 Continued to believe in self despite confusion
“I didn’t want to be a teacher. So I was like in a fog. But I also added English and linguistics. I took a lot of Shakespeare just to spite people.”
[A bit of a rebel?]
“I didn’t want to be a teacher. So I left.”

J. Deafness first experienced as external…
“My deafness got in the way.”
[As if it’s a nuisance rather than a way of experiencing world.]

J. Then internal…? Struggle around accepting Deafness?
“So I started with the young ones and did a lot of play therapy and I was struggling with my own identity. I missed my culture. I grieved a lot. I grieved a lot.”
“What’s the matter with you? You talk. That means you’re hard of hearing. I said my hearing has nothing to do with my speech today. My ears are broke but I still talk.”
“It wasn’t until I was 40 that I said, I’m deaf. That’s it, I’m deaf. And really feel strong that I’m deaf.”

J3.1 Deafness as a complicated lived experience
“There’s one issue when people ask me this question, it’s not cut and dry because deafness has interfered with everything I got in my early years, my education, college.”

J.4. Then experienced as external again [after she got implants?]
“I don’t have to deal with my deafness right now because I was traveling a lot.”
[How does one not deal with deafness? What is this like for her?]

J.5. Addresses many challenges by “becoming” more hearing/passing
“My career started to take off again when I got the implants. But, uh, that 30 years in between, hard of hearing, deaf, I served [the deaf].”
[As if she couldn’t be successful before? Was she not successful in serving the deaf?]“[When hearing started to go], it was affecting, you know, my work. I could not find work even in the deaf world.”
[This is interesting — why not? She is fluent in ASL.]

“And then I wasn’t going to be a dumb jock either. So I go to the [name retracted for privacy] and I get my PhD. So I’m a scholar and a top athlete. These are the things we tell
ourselves. I’m not going to go there. I’m not going to be that stereotype.”

[This here may well explain her decision for implant — she holds some internalized fear that deaf = dumb? This internalized fear may also stem from childhood experiences and early feelings of worthlessness and being told how to be.]

“Without these [implants] I am deaf. Deaf—deaf. And I can’t hear myself. I literally broke out in a sweat.”
[Feels rejection/doesn’t feel fully comfortable now without the implants.]

J5.1 Implants result in fewer challenges
“Well through the years, not so much now because the cochlear implants have really helped me.”
“Now I can hear on the phone […] it’s not perfect hearing, but it’s so much more than what I had.”
[Sense of pride…]

“When I first got into the deaf world, again it wasn’t by choice, because I had to.”
[Because of being told she had to by superiors?]

“It’s interesting because I have a unique person in me in terms of being hearing then going deaf and then regaining a lot of my hearing back with this. But I’m still deaf without them, if that makes sense.”
[“Deaf without them” – suggests that she now sees deafness as more externalized?]

[Wonder if these comments by deaf patients influenced her decision to get implants?
Rejecting implants for ASL might have felt too scary, especially if she wanted to work with hearing patients?]

“The difference in the way a client is saying something. Their voice, their tone, and it doesn’t match their nonverbal behavior or facial expression. In the past, if you’re really deaf, I’m not going to catch that.”

J5.2 Experience of identifying as Deaf = experiencing anxiety
“Still have the old deaf way about me. I’ve done for many years in terms of, am I going to hear this person? Am I going to be able to work with this person in a comfortable setting at his or her pace? Am I going to understand really clearly? Is this someone, you know, I might not be able to hear well for whatever reason and lip read? All these different things.”

J5.3 But ends up feeling more isolated?
“People say you’re not deaf.”
“Most of my career, very lonely, isolation. There’s only a few deaf therapists. Especially those with acquired deafness.”
“I have not heard someone actually just challenge me and I was in another country. I was like, thrown by that (Laughing.) It angered me.”
[Thinking here of the phrase “deaf anger”…she wants to pass but she also doesn’t want to be told what she is/isn’t. She doesn’t really fit into prescribed boxes; in fact, her understanding of herself as a deaf person and therapist is still ongoing and fluid.]
“Or go out with other colleagues, your deafness. I can talk all day to Sunday, but it’s not going to help me hear.”

J5.4 Desire to be accepted by Deaf community even after passing/implants
“The constant fighting with the deaf world. My answer to all of this is people telling me you can’t do this or you can do that, or because of what they do and deal with my deafness in these clinics my answer was private practice.”

J5.5 Still faces challenges around accommodations
“I have to fight for an interpreter, and fight for an interpreter, and fight for an interpreter.”

J5.6 Continues to worry about rejecting even after implants
“So the challenge is, even though I do really well with this, for me, psychologically, I don’t want to risk the rejection of – okay, I’ll say I’m deaf or I have trouble hearing and you come back and give them the choice. I’m afraid they’ll hang up or they’ll come and decide they never want. I never lost a client where they actually showed up.”

J6. Ongoing challenge of experiencing world as simultaneously hearing and deaf:
“That’s one of the challenges, too. You do so much more to get to the starting line. We’re all so wiped out and everybody else it’s like, go. That’s why it’s so important for us to, you know, self care. (Laughing). Because we use our eyes so much. And our brains. Our brain, I think, is working even more than the normal therapist. We’re working to hear, too. Even with the cochlear implants, I’m still working to hear.”

“One of the other challenges is, you know, I call it lip-guessing. Why? Because in the English language. Someone says to me, you know how they say, “Oh, you’re deaf you lip read.” I say, I lip guess. I say it with humor and this is probably the workshop tomorrow, too. Only 30 percent of the English language is visible on the lips. Only 30 percent. Some will say 30, 35. If you look it up, only 30. So of course, how are you expected to see language that 65 percent is not there? So lip-guessing, I call it, is smart knowing what the conversation is about. The subject. Anticipation, experience, and lipreading. Lip-guessing.”

J6.1 One foot in both worlds
Isolation within communities?
“But you get that ostracization in the deaf world too if you’re not culturally deaf or born. I was dealing with that in the early part of my career.”

“Because I wanted to be a therapist and I’m working as a therapist in the deaf world, I’m happy to give up that social life in the deaf world. It might have been different if I had actually been deaf culture.”

[Sense of loss?]

“You have a PhD. Or you cost too much.”
[“You have a PhD” — as if the Deaf community feels distanced from her? Would she have better reached that population if she marketed her MSW?]

“I rarely use the word deaf. In the hearing world. My deaf clients come, what are you? Or they have heard about me because I had a foot in the deaf world and a foot in the hearing
world. I got the rest of me in the hearing world and a foot in the deaf world. (Laughing). Okay.”

J6.2 But still feels most comfortable in hearing world?
“But with my hearing clients it’s like I come home and I feel more confident. I feel like more me. You know? I’m doing the salute. I’ve been hearing, hard-of-hearing, deaf, then deaf to hard-of-hearing to [having more] hearing now.”

J6.3 Sense of loss in path not chosen?
“I already felt like I lost four years [when deciding to go for MSW b/c shorter time commitment]. That was that life-death personality from growing up. And then I lost the – the deafness lost that – I’m not going to make up time. In retrospect I wish I would have got my MD in psychiatry or clinical psych because of all the politics going on now.”

Therapy Dynamics

J7. Self Disclosure Process Varies Depending on Comfort Level/Client
“I would say, like, if I have to repeat, or say that again, by the way I have a hearing problem. I didn’t go into I’m deaf. I don’t go into all that.”

“But I will not reveal my deafness on the phone. When we get here and it becomes an issue, I will say flat out. I didn’t hide it. I will flat out tell them if it’s an issue, okay? I don’t bring it up immediately. If it gets to be an issue, “Oh, by the way,” I will minimize it. I never had a client who had an issue with it.”

[Does she minimize disability b/c fears rejection?]

J7.1 Disability experienced as a greater challenge for Jaime than clients?
“And she’s talking and I couldn’t catch everything she was saying. I had one, but it was like lopsided. And I’m thinking, I was totally inward on myself. What am I going to do? How am I going to handle this as a therapist? What is the right moment to say something, not to interrupt? But I was over there for a short time to help her with something she was doing and then I was going to move back over there and then I thought, okay, should I just let it go? And then wait until after the session and say nothing? But then I was missing so much [with dead battery] and I said, “Oh, hold on a minute.” She said, “What’s up?” I said, “I’m sorry I interrupted you, battery died,” with a little bit of humor. She looked at me. I said I have implants, I don’t hear very well without them. “Oh, okay.” No big deal. No big deal.”
[There seems to be some possible anxiety around not hearing, as if with implants she can no longer access identity as Deaf person?]

J7.2 To not hear/understand is to possibly lose control?
“That has never happened because I made sure I have everything, you know how that happens?”

J8. Deafness less about identity (since implants) in therapy
“I’m very conscious about don’t want my problem – I call it a problem – my deafness to get in the way. I’m trying to build a practice. And I don’t want to lose a client or whatever.”
[This is where I start to feel confused because at earlier points in interview Jaime says she identifies as Deaf and misses not being part of that community. But with clients, it seems
like she has to present as hearing and that deafness becomes an externalized object/problem that needs to be dealt with. As if she has to wear multiple hats?

“I’ve had more trouble in the deaf world than in the hearing world in terms of getting clients, private clients.”
[But it seems like she wants d/Deaf clients too…sense of loss?]

“But with hearing clients, I really – I think it’s more of me than it is them. In the past. To me, okay, I’m not going to work with – because how am I going to hear?”
[Is she co-creating her own difficulties out of insecurities?]

J8.1 Outright criticism of deaf world may also explain desire for implants?
“And I can understand it because deaf therapists they’re no good. Or deaf therapists, you know what that means? That means everybody will know your business. Small world. Grapevine. I’m not involved.”

J8.2 Limits interactions with Deaf Culture to therapy room
“Because I wanted to be a therapist and I’m working as a therapist in the Deaf world, I’m happy to give up that social life in the Deaf world. It might have been different if I had actually been Deaf culture.”
[Sense of loss?]

J9. Transference with deaf/hearing patients
“That I was really listening to them and I gave them their time. But I also had a lot of clients who fall in love with me because I was paying attention too much. So I had to deal with that, I think, maybe more so. I really pay attention.”

“I’ve had deaf clients do it too for transference reasons. But there’s also, of both sexes, with deaf clients, ‘You understand me.’ ‘We can communicate.’ Or, ‘You’re deaf like me, you speak, you sign.’ And ‘I can’t meet anyone else like you, let’s go out for a drink afterwards. Can’t you make an exception?’”

J10. Uses countertransference reactions to understand self and client
“I said, ‘My hearing problem is not a problem working with your son. I don’t need to work with you. And I never became defensive like that in any therapy in all these years. I remember a red flag went off in my head, ‘oh, you have issues. This is something you have not resolved yet.’”
“It was her issues and my issues were clashing mother/daughter thing. And it was disability stuff. But I didn’t think of it in terms of the mental illness schizophrenic and the disability depended on her. She had a love-hate relationship with it. And I had a love-hate relationship with my deafness. There you go. (Laugh).”
“To this day, I wait for that call. He’ll come back. Or he’ll call. When he’s more healthier. That’s what I tell myself. Or even the mother.”
[Desires to reconnect with this patient — maybe sense of shame/loss around losing him as well as her negative reaction to mother’s comment?]

“In hindsight, I should have been more compassionate and not gotten defensive and said to
her, what’s going on? Rather than focus on me.”
“You know as a therapist, and an individual. When I meet people who are deaf like me, I’m professional, highly educated, and working on their own and I find myself sometimes attracted like we all do with some of our therapy relationships. And I’ve had to be on my toes about that and I think part of that is, wow I wish I could walk out the door and meet someone like that. You know?”

J10.1 Trusts in therapy process: What’s important will come up again
“But if they’re in an intense story or a moment in therapy, I’m not going to laugh about that. Or I’m not going to ask them to repeat it two or three times […] But I do find myself even now I still do the old lean forward or something very subtle and I will wait for the appropriate moment if at all and ask to repeat. Something that intense, something very painful that I think can let it go, it will come up again.”

J10.2 Uses moments of mishearing in best interest of client
“But if it’s something I really need to know, oh, yeah. I will ask. I may move closer. I will say that, I’m going to move a little closer. I know this is really very painful for you and I truly want to be able to understand and hear. Not so much understand, but I want to be able to hear you.”
“It’s very important what you’re saying to me and they’re, like, thankful to repeat it because you’re saying it’s something very painful or powerful for you, I want to be able to hear this again. You know, fine. Then say, oh, will you repeat that please?”

J10.3 Importance of time/experience on accepting difficulties within therapy
“You also have to, I think, as a deaf person, I don’t know if it’s true for you, especially someone who’s a scholar in that therapy relationship, how we’re always thinking ahead. With deaf people or people with disabilities, you have to be one or two steps ahead of everyone else just to be at the starting line. Does that make sense to you? And by the time you get to the starting line you’re wiped out and everybody else can go (Laughing). You know? So that’s what I mean here. It’s very significant. So I think, I try to be a little step back, and not so anxious with that. And this comes with experience over the years that I’ve been able to sit back…”

J11. Mixed Support in graduate school and beyond
“She told me one thing that stayed with me all these years, something comes up and you miss it, not so much because of the deafness. If you miss it in therapy relationships, ‘Oh, I wish I’d said that during this time,’ or, ‘I should have’ – you know how your mind is going a million miles a minute? And you’re doing your observation and you’re listening and you’re listening to what’s not being said and the whole thing? It will continue to come up. Until it’s resolved.”
“For example, when I first got to [name elided] was supposed to have had swapped with the supervisor I got because, “Oh, we have two students coming in, one’s deaf, one’s not. She knows some sign but she was – switch with me.” It was her subordinate. ‘Take her, I’m taking the other one.’”
[Rejected from first day b/c of perceived assumptions about disability/deafness.]

J12. Interview Dynamics: Here and Now
Trustworthy and vulnerable

“I’m going to start with kind of broader questions and get more specific. Can you tell me a little bit about how you went into psychotherapy in your training?”

R: How I got into psychotherapy?

I: Yeah. Or psychology?

R: The age old thinking, saying, is we’re all in it for our own stuff. You know? And I would be pretty honest in saying, it’s natural for me. (Laughing) But also, I grew up in a home that was – had an alcoholic [caregiver], the worse verbal abuse.”

[Her openness seems to also suggest loneliness and desire to connect with another deaf therapist.]

J12.1 Pauses feel like she’s coming up for air before diving down again.

“…I wanted to be a psychiatrist. That or a pediatrician. That way I could protect the kids. Okay? (Pause.)

Along the way when I got to college I realized how far I come…”

J12.2 Use of humor: sometimes just about being funny other times used to distance self from memory?

“I didn’t know sign language. And I was taught it was not nice to stare either. (Laughter.)”

[Interesting merge of cultures: Deaf and the South.]

“And my advisor said you’re not going to be a doctor. You’re not going to hear your patients, you’ll send them all to the morgue.”

“And then [family member] killed himself. So that’s how I got into psychotherapy. (Laughing)"

“So I walked into the office and I’m in a dress in heals, skirt, and I’m talking. She nearly fell out of the chair. She said are you deaf? I said yep. And we just started laughing.”

J12.3 Relives experiences through tangential narrative style?

“I went from playing for the number one [sports] team in the nation at the University of X. It was [coach’s name elided] in my day. But I played for her. She wasn’t married (laughing) when I played for her. […] I’m taking the long way around but I’m getting to it.”

[Taking the long way around is part of her narrative style. She’s vividly remembering her experiences, such as being on the renowned [name elided] [sports] team. In fact, more than half of interview is spent talking about childhood/educational experiences rather than therapy dynamics: this may speak to what feels most urgent for Jaime to discuss? And also points to lasting impact of these experiences on her profession as a therapist and d/Deaf identity.]

J12.4 Avoids questions about therapy process to stay on topic w/ what she knows best? Or is this a cultural way of answering my question?

“I: Do you bring it up yourself in the first session? How do you self-disclose?”

“J: It depends. It depends on who. I don’t outright do it, but I don’t keep it a secret either. You know, people want to Google me they can. […] What are the things you hear common between sports and deafness? You hear, oh, deaf and dumb. Or dumb-jock. Right? I was determined. At that time, I didn’t understand that dumb meant dumb. I’m mute. I was determined when I became deaf, I was stupid. And then I wasn’t going to be a dumb jock either…”

280
I: So going back to when you talk about being deaf with your client, can you tell me about a specific time that you have disclosed your deafness to a client…”

[Talking about stereotypes about deaf rather than answering my question? As interviewer, I feel a bit confused here. Yet, this style of storytelling (providing all details), even if not necessary is unique to Deaf Culture.]

“The constant fighting with the deaf world. My answer to all of this is people telling me you can’t do this or you can do that, or because of what they do and deal with my deafness in these clinics my answer was private practice.

I: So private practice is your way of dealing with it?

R: Challenges, even now I can go to some conference and I don’t have to worry about it. I pick and choose and it’s like revenge and it’s working okay.

I: Revenge?

R: (Laughter.) Yeah, it became like what’s next.”

[Revenge on what? Childhood trauma? The larger hearing world and their authority?]

J12.5 Examples of “speaking” in ASL.

“I ended up doing my student teaching in “X” as “XXXX”. The high school – they put me to teach math. I’m not math. I’m deaf culture, deaf culture shock.”

J12.6 Doesn’t directly answer questions related to therapy processes and disability: is this because she doesn’t identify as Deaf anymore? Confusing.

I: Can you think of a time when your deafness has impacted the therapeutic alliance with a non-deaf client? If you can, can you tell me a specific story?

J: Well, not a deaf client. I mean not a client whether deaf or non-deaf client directly. But a parent. Of an adult hearing child.”

J12.7 As trust/rapport builds in interview, Jaime delves deeper about therapy process and also stays on track

I: I feel like that, too. Sometimes after I’ve had, like, three sessions of lipreading I’m so tired. Or I’ve been all day in classes with a transcriber and I’m reading a laptop.

J: You’re reading constantly, your eyes are being used 24/7 practically. And other times you sit there and you just close your eyes for a minute and how they burn and you’re thinking I’m just so tired.

I: I don’t know if this is true for you but one thing I noticed is because I have to look at the client when I talk to him and understand the words audiologically, sometimes I find that my psychodynamic interpretations happen later because I can’t –

J: You’re focusing so much –

I: I can’t listen passively. And I can’t look away to think about something. So it’s like I’m always trying to get the superficial.

J: You’re always working. Yeah.

I: It makes it harder sometimes to go deeper as a therapist in the session, like in the here and now with the client, because I feel like I have to understand them on two levels. Both like what they’re saying and then from a psychodynamic perspective, too.

J: And what they’re not saying.

I: I can, but sometimes I feel like my best thinking happens after.

J: Well, sure. You’ve had time to simulate. During my twelve deaf-deaf years. But not so much now because they have given me sound to hear, so I can look away.
I: I can’t do that. Sometimes
[Second half of interview — opens up more about conflict/struggles accepting deafness and
the difficult moments with clients/not hearing things. This may speak to our growing
alliance? We both seem to feel more comfortable as interview progresses? Rapport and flow
of interview feels different — we are staying on track with conversation.]

J12.8 Sees experiences as similar but in fact may be more different than she thinks?
Jaime stated that it was nice to talk with me, someone “deaf like her.” Aware of this
connection, also aware that we have different experiences. When I describe how it’s
sometimes hard to go deeper in session because my focus is on the audiological rather than
psychodynamic level, she stated she had that problem before she got implant. Not sure how
that made me feel? Especially given that implants are not an option for me.
Interpretive Phenomenological Analysis
Participant Themes with Excerpts from Transcript

Skype Participant: “Bella”

[Note: Due to the unique communication challenges, the heart of this interview is discussed in Chapter 5.]

Super-ordinate themes shown in **bold and underlined**
Working themes shown in **underline**
Working implicit themes shown in *italics*
Textual support cut and pasted from transcript
[Thoughts about theme in brackets]

**BE1. Challenges are largely with colleagues/ agencies**
“When I was at the agency there was little to no understanding of my disability […] Most of the clients were very helpful [and] let me write or they would write large or read to me. My colleagues were not at all as understanding as my clients.”
“I think it impacted my relationship with my colleagues much more strongly. As I said before for some of the teenagers it taught them compassions [sic].”
 “[Clients] were never so mean. They would always ask why I don’t wear glasses even if I was.”
“If I told my supervisor that the therapeutic relationship was being compromised and I think the client would do better with another therapist, the supervisor pretty much said tough work it out.”

**BE1.1 Psycho-education big part of her role**
“I explained that being blind was not a game, was not fun and was not something to be taken lightly.”
“I think I taught him more than he taught me that semester.”
“I was expected to read things that I could not. I had to commence a lawsuit.”

**BE1.2 Holds some anger/resentment at colleagues?**
“It caused a lot of frustration and hurt that other therapists were so callous.”
“When my colleagues joked about [my disability], I took affront and got very resentful and reactive.”

**BE2. Mixed reactions from clients following self-disclosure**
“When I could read sometimes the clients (they were almost all young people) would either make jokes or become extremely helpful.”
“I think that for some of the clients it was eye opening, they could feel for someone other than themselves.”
“One or more times the client got very aggressive about the sight disability. It made me uncomfortable. I had to get in my head that it was more their fear, or they were used to being bullies and this is a way that they cold bully me and detract from their own issues.”
“I think that I get uncomfortable when they afford me too much compassion. It is a disability I have to deal with it and I get a little embarrassed if we go on about it. So I have to redirect to something else.”
[“Have to deal with it” – speaks to problem-solving attitude?]

**BE2.2 Helping behaviors allow clients to feel more in control**
“I felt that impacted the relationship because some wanted to take care of me (laughs).”
“For others it perpetuated the caregiver role that they had in their families.”

**BE2.3 Energy is spent responding to colleagues’ negative comments than clients?**
“I became so reactive to the workers, that when a young client said something offensive it didn’t bother me very much.”

**BE2.4 Younger generation responds differently?**
“They would want to know about my eyes, how people treated me they would and to know a little too much, remember teenagers are very nosy. They would ask other clinicians questions.”

**BE2.5 Doesn’t want to be seen as having multiple disabilities? Or maybe doesn’t see hearing-impairment as a disability?**
“I don’t know if I ever disclosed [hearing impairment] to the clients. I say that I just didn’t hear you. They probably think that they [mumbled] or something like that.”

**BE2.6 Self-reflection**
“I have to keep rechecking myself. Also when it is my agenda and I know the client well, I will tell the client that I might be speaking of my rather than of their agenda.”
“I thought it was sweet and very thoughtful [that clients wanted to help]. However they were not there to help me. But I realized that for some of them it was very therapeutic.”

**BE2.7 Style of doing therapy fits with experience of being-in-the-world?**
“I: You share a bit of your own process and experience… it sounds like?  
B: Yes all of the time. I am a story-teller. The clients usually like stories.”

**BE3. Interview dynamics: Here-and-now**

**BE3.1 Generalizes/makes assumptions about others?**
“I: Can you say more about ‘always doing the best?’ How do you understand that?  
B: I do not want to direct the client on my path but rather on his/her path […] that is very hard since often the decisions that one makes is quite poor.”  
[Generalizing? Do all her client’s make poor decisions? Wonder if her generalized response is a reaction to being discriminated?]  

“B: Teenagers are never vulnerable, remember that…  
I: Teenagers are never vulnerable?  
B: They think they can handle everything and that life will not get them physically, so someone they were close with having an health issue was scary for them.”

“I: When you wrote, “B —, this isn’t you. Come on, you can see” was this from a specific client that you worked with?  
B: It was a number of clients.”
BE3.2 Speaks in platitudes
“Sometimes getting clients to face their demons is a mountain too high to climb.”

BE3.3 Has difficulty responding to interview question
“I: You talked a little about this before but how have you self disclosed your sight disability to your clients? When do you self disclose?
B: When I had a patch on my eye it is a no brainer. If they give me something to see and I can’t I have to disclose. Now with so much social media and they want me to look at pictures or emails I have to tell them because I have to close my left eye to read sometime and it looks strange.”

BE3.5 Use of Laughter to mask possible anxiety?
“B— why can’t you see. come on you can see this can’t you. (laughs).”

BE3.6 Laughter suggests possible discomfort at being cared for?
I felt that impacted the relationship because some wanted to take care of me (laughs).

BE 3.7 Difficulty with being on the same page using internet chat/capturing nonverbals
“B: I do not want to direct the client on my path but rather on his/her path
B: that is very hard since often the decisions that one makes is quite poor
I: As if you sometimes feel like your own agenda gets in the way…?
B: yes absolutely. I am not a very good speller (Laugh)
B: that’s ok!
B: How do you work with this challenge?”
[…]

“B: I worked for a women’s center. where there were a bunch of strange people. they wanted total control which was in my mind totally counter to the mission of a woman center. so I had to have enough confidence to challenge and omit
I: I noticed you tapped your head when you were recalling that!
B: it was very stressful.”
Interpretive Phenomenological Analysis
Participant Themes with Excerpts from Transcript

Purple Communications Participant: “Brenda”

Super-ordinate themes shown in **bold and underlined**
Working themes shown in **underline**
Working implicit themes shown in *italics*
Textual support cut and pasted from transcript
[Thoughts about theme in brackets]

**BR1. Challenges related to lip-reading/getting everything**
“I’m thinking, processing, trying to understand what’s going on in the client’s head, and to process it all can be very draining.”

**BR1.1 Certain pathologies poses unique challenges**
“It can be very, very stressful [working with Borderline patients]…their facial expressions, their behaviors, and having to think about it, to control my reactions, countertransference, trying to think and respond to them.”

**BR1.2 Cochlear implants help with this challenge**
“I have had a time when I unconsciously would take my hearing aids off after a stressful session but that was a long time ago. But now I have cochlear implant it helps a great deal. So I am not so tired or stressed out.”

**BR2. Importance of time/skill in overcoming anxiety around disability**
“Anxiety, of course. When I first started, I was afraid that I would not be able to follow and also wondered if they would think I was incompetent (Chuckles).”
“But the more I did this the more I felt comfortable I grew up in a hearing environment and have a lot of exposure talking with hearing individuals.”

**BR2.2 High expectations of self – possible coping mechanism?**
“With struggling to understand everything. I have high expectations of me to understand everything, and to follow what is being said.”

**BR3. Sense of Self Derives from Connecting with both HOH/Hearing Therapists**

**BR3.1 Being part of both Deaf/HOH worlds decreases overall isolation**
“Very positive. Univ of X School of SW and community planning. […] It worth being in a world where you can interact with everyone, such as the deaf, hoh, late deafened, and hearing, and it helps decrease the isolation.”

**BR 3.2 Desires to connect with other HOH participants**
“Why I became a therapist to understand myself and I never had a therapist who understood the deaf and hard of hearing and because of that I became I think a better therapist when I started working as a therapist.”
“Wish I had one [therapist] in jr. high school. And someone who could explain to my
parents what I was going thru I went thru some isolation and depression.”

BR 3.3. Self-confidence increases when she sees people like her who are practicing
“I think sharing my experiences with other therapists like me helped. Other HOH and deaf therapists. To share some of our feelings and concerns and realize we share the same fears or thoughts.”
“I can relate and talk with her [another HOH therapist] she does not sign but both of us have cochlear implants.”

BR 3.4 Possible isolation within therapy community?
“There are not that many hearing-impaired therapists out there!”
“But to work there everyday – it can be isolating and they would need a lot of training and education about working in and around other deaf and HH individuals. We are conscious that we are both different.”

BR4 Patient-therapist relationship is key to success and overcomes disability
“But I know that when I and the client get to know each other and communicate with each other the deafness part fades away. When we focus on the relationship. Same that I do with the deaf and hard of hearing, picking up body language reflecting back […] I think it goes back to having and building a relationship.”
“I am more empathetic and sensitive. I pick up their feelings and their body language.”

BR5. Seems comfortable/able to own disability
“I always do [self disclose at beginning of session]. I would look at them after introducing myself, check in and see if we can understand each other. I take full responsibility.”
“Some go right ahead and keep talking about their problems. Some became a little stunned. Some act like it isn’t a problem or they want to be sure that I can understand them. Different reactions.”

BR5.1 Fears rejection from hearing patients/colleagues?
“Now I see myself a deaf person but with a hearing person I say I have a hearing problem so I do not scare them.”
“But there is another place […] where I see other hearing professionals and am dependent […] that kind of atmosphere is not comfortable but I am used to it.”

BR6 Interview dynamics: Here-and-now

BR6.1 Participant Sees Self in Interviewer
“When I was young I was very brave like you, but now too tired to advocate or to speak up in a new hearing place. It doesn’t change maybe the therapists have never met a deaf or hard of hearing person so it makes no sense to educate all about deafness if they will never meet one again. Interesting report you are doing but I can relate to what you must be going thru now.”
[Desires for me to know that it gets better? I find myself wanting to reject the notion that I’m “brave” or that she knows what I’m “going thru now”?]
deafness and HIPPA here…”
[She seems more comfortable talking about workplace than specific clients?]

“I: Can you think of a specific response from a client that’s been particularly meaningful? Positive or negative?
B: Some go right ahead and keep talking about their problems. Some became a little stunned. Some act like it isn’t a problem or they want to be sure that I can understand them. Different reactions.
I: Can you think of a time when you’ve had strong feelings about your deafness in response to a client’s comment or experience?
B: I can’t think of it at the moment.”
[I don’t ask her to expand. It seems like when interviewee has trouble expanding early on I stop trying? This is more apparent in my first few interviews than later on when I get more skilled.]
Interpretive Phenomenological Analysis
Participant Themes with Excerpts from Transcript

Email Participant: “Jake”

Super-ordinate themes shown in bold and underlined
Working themes shown in underline
Working implicit themes shown in italics
Textual support cut and pasted from transcript
[Thoughts about theme in brackets]

JK1. Challenges within workplace, not clients
“Difficulty [accessing] the notes of case managers and psychiatrists,” thus impacting the care he provided to patients.”
“Well, yes. I was the only visibly disabled student and trying to find readers, there was no disabled student program at that time. There were no personal computers either and my electric typewriter wrote out my papers. It was not an easy time.”
“Electronic Medical Records (EMR) — my blindness is affecting my documentation. As these are not accessible.”
“Years ago staff made it difficult to visit patients on the psychiatric inpatient unit, this was handled, corrected. More recently a cavalier attitude by management caused me to receive my first write-ups of my career, for such infractions as 15-minutes of over-time where the time clocks had been changed to be non-accessible. This and other write-ups made consulting an attorney necessary; a letter from an attorney helped to erase those write-ups.”

JK2. Clients experience him as less judgmental than others
“Some patients have appreciated my blindness, saying that they feel less judged by their appearance, this especially from patients with body image concerns.”
“There have been several examples, most commonly with folks with body dysmorphic disorders, voicing their relief that I was unable to see them. People are, likewise, interested in telling me about their weight loss/gains, their attire & the like.”
“One patient, a woman with a schizoaffective disorder stated that she felt more comfortable with me as a blind person, but later told of having been raped by a blind man while in college. The transference issue was right out there on the table. We discussed it and her reactions. Her deceased fiancé was visually impaired as well as it turned out later, complicating things further. It is all grist for the mill, as would any transference issue.”
“…she was overweight and did say that she was glad that I was unable to see this.”

JK3. Mirroring of selves
“Most of the time, clinically, my blindness permits a closer relationship with patients who feel a kinship with disability as they, too, are disabled (psychiatrically).”
“At times I am the one to introduce the topic, saying something such as, ‘we both have disabilities, management of our disabilities is the trick we need to learn.’”

JK4. Invites client exploration around disability
“I invite questions about my blindness or about any other aspect of our meeting.”
“I answer with as little personal material as possible, bringing the discussion back to the
patient as soon as their concerns or interests are satisfied.”
“Often patients will ask if I can see them or if I see shadows. I answer by identifying that I can recognize the light sources in the office, but that I cannot see them. If they express feelings of sympathy or concern I ask them to look at their hand, then to move the hand to the back of their heads.”
“This experience of their own areas of blindness seems to help them to see blindness in my own terms, as a bother and nuisance, but not as a disabling condition.”

JK4.1 Countertransference issues at forefront of therapy?
“Thinking through it I feel that my uncomfortable with her is with her neediness. Apparently I have some of the same issues. I recall a youth telling me of being sexually abused and thinking how glad that it had not been me, only later to recall that it had happened to me in a similar fashion. I think that her blindness issues may be some of my own issues that I would rather not address.”
[This is the second time Jake has mentioned having issues around attachment/neediness with patients. I'm aware of my own slightly uncomfortable feelings about this and wanting to know more but also not wanting to ask too many personal questions via email.]

JK5. Uses disability to psychoeducate/mentor patients
“I have used myself as a model to some patients, saying that due to my blindness I have had to learn to do things differently than others, as they with ADHD might, too, need to do things differently.”
“I see this brief exercise as psycho-education and evaluate if the patient is able to extract from this experience to other areas.”
“This experience of their own areas of blindness seems to help them to see blindness in my own terms, as a bother and nuisance, but not as a disabling condition. I see this brief exercise as psycho-education and evaluate if the patient is able to extract from this experience to other areas.”

JK5.1 Can’t really focus on body b/c of sight disability? Draws strength from language?
“I feel that I listen to the words and the underlying messages as well, but this isn’t a result of blindness, or I just don’t relate it to that Any good psychotherapist will listen to both the words spoken as well as the themes, the tenor of the voice, the cadences, and the moods and affect that sit behind the words.”

JK6. Patients feel like he understands them
“Her response was that I am the only one that is trying to see her for her and doesn’t judge her or try to change her or tell her that all the things she is doing are wrong. She felt that I got her because rather than focus on her questionable behaviors I was trying to see why she was making those choices and what was the original root of her motives.”

JK7. Speaks in broad terms, rather than specifics. Meaning is unclear?
“The most important experiences have been those where change occurred, aided by my interventions. The angry man who allowed me into his home and allowed me to help him towards achieving a driver’s license; the young woman who spent her high school years looking at the floor who became a socially active college student; the man with a schizophrenic disorder who stood proudly in an Elvis costume and sang on stage […] the
young man who decided to use his anger to get back at his step-grandfather by graduating high school; and more and more.”
Interpretive Phenomenological Analysis
Participant Themes with Excerpts from Transcript

Email Participant: “Donna”

Super-ordinate themes shown in **bold and underlined**
Working themes shown in **underline**
Working implicit themes shown in *italics*
Textual support cut and pasted from transcript
[Thoughts about theme in brackets]

D1. Confusion/feelings of anger at workplace
D1.2 Feels uncared for?
“I am actually not happy here (a big part is the way they treat me as HOH) and I actually just put in my resignation. Ill be leaving Feb 17th.”
“If I thought suing would make a difference, I might consider it but as far as I’m concerned, the VA doesn’t care and I’m not going to waste my time.”
“Colleagues have not commented on [my non-verbal] skills.”
“…current experience is the most trouble I’ve ever had with my hearing and I am choosing to leave because of it.”
[Emphasis on leaving makes me wonder if she really wants to leave or if she feels like that’s the only option? That she is choosing not to fight back suggests exhaustion/isolation/feeling helpless?]

D1.3 Been denied opportunities that were given to others
“This postdoc has pushed me backwards as they are very critical of my work and have taken experiences away from me.”
“They took away groups I was running, specific types of clients, and supervision of the interns.”

D2. Does not feel understood
“Clients were usually puzzled if they found out what school I attended, saying something like, ‘Oh Gallaudet? I thought that school was for deaf people?’”
“Doing nothing because I appear ‘hearing.’”

D2.2 Sometimes wants to pass as hearing
“My research was on the impact a third party makes to the therapeutic alliance. I do not want to bring in an interpreter or CART services if they are not 100% needed.”
“In the hearing community, I tend to only disclose when relevant.”
[Does her research suggest that a third party has a negative effect? Didn’t feel comfortable writing again after she was short in last email.]

D3. Struggling to maintain self-esteem
D3.1 Loss of self/self-confidence
“As a result, I am losing my job and lost confidence in my skills.”
“….getting a new job working with deaf and I am already worrying about my skill level.”
D3.2 Insecurity underneath anger?
“I become anxious and conscious of my skills with skilled signers, hoping that they understand me.”

D3.3 Desires to convince me that negative experiences at [gov’t org] are an anomaly?
“I never had big issues with a job and my hearing before. This is the first instance where they did not work with me.”

D4. Difficulties with colleagues/workplace
D4.1 Supervisor assumptions experienced as negative
“Currently, the administration and my supervisors are the ones making rude comments. For example, my supervisor assumed I misunderstood someone because of my hearing loss.”

D4.2 Feels unsafe at workplace
“I had already been called ‘defensive’ when trying to explain my point of view so I did not feel safe to share my thoughts freely.”

D4.3 Lack of accommodations
“I have to audiotape sessions, no access to video, and some consultations take place over the phone or using videoconference that shows people at a distance (can’t lipread).”
“In assessment, it can be a problem because I cannot always ask for repetition and exact verbiage is important with some screenings.”

D4.4 Expects others to help, yet doesn’t ask for accommodations? Confusion around expression of self?
“I generally appear very ‘hearing’ meaning that people do not generally know that I am HOH. Due to that, people tend to forget I may need accommodations and stop offering. I then get tired of asking and usually let things go.”
“I do not want to bring in an interpreter or CART services if they are not 100% needed.”
[She expects others to offer her accommodations but she also rejects them if not 100% needed. What does this mean? At the same time, she wants to pass as hearing? What is she feeling?]

D4.5 Hearing clients are generally not the problem
“The problems I am having now are related to supervision and consultation, not with clients.”
“With clients in therapy, I have not had an issue. If I miss something, I ask them to repeat.”
“With hearing clients, it has been mostly positive. I have no experienced problems with hearing clients.”
“Hearing clients have not offended me.”
“My hearing clients have been appropriate with my disclosures.”

D4.6 But the rest of the hearing world is problematic?
“When I go out into hearing populations, I tend to get two reactions- 1) Sympathy/Overkill in trying to address my needs, 2) Doing nothing because I appear ‘hearing.’”

D4.7 Anger at deaf clients though for not being as accepting?
“With deaf clients it varies…”
“Deaf clients vary – either they are happy that I have some hearing loss or unhappy that I’m
not deaf enough. I also see problems with the deaf community because I’m not ‘deaf enough.’"

D4.8 Feelings of anger at the world
“Yes, I have a group of deaf friends where I am the ‘hearing friend’ and a group of hearing friends where I am the ‘deaf friend.’ I’m never equal.”
[Her responses are brusque, direct, and seem to carry underlying anger and/or sadness. She seems to be asking, Where is my place?]
“I am stuck in the middle of two populations. I’m too deaf for the hearing world and too hearing for the deaf world.”

D5. Non-verbal observant skills have positive impact
“I think I am more observant with my clients. That comes from being a strongly visual-based person which I think is related to my hearing loss…observant in two areas 1) appearance 2) demeanor. I can usually tell how people are doing by the way they take care of themselves and dress.”
“…observant to their demeanor, as in, being able to tell if something is making them uncomfortable or they may be lying by their body posture.”

D6. Ambiguous feelings about interview
D6.1 Assumes I know what she’s speaking about
“With deaf clients I am open too because that is the culture. You share much more with deaf clients then hearing.”
“Since most of my colleagues are from Gallaudet, you can imagine they understand well.”

D6.2 Doesn’t expand on answers/answer question
“I: Have you ever felt that a hearing client has responded negatively to your hearing loss? (E.g., in comments, by not returning, etc.).
D: I can not think of any possible examples.”
[She returns right to the present situation. It maybe that this interview isn’t going well because of her own stress levels and ability to be present, which makes sense. I find myself wishing I could say something helpful.]
“I: What are some of the most important experiences that have shaped your development as a psychologist?”
D: I think the actual clinical work is what helped me to develop as a psychologist.”

“I: What are some major challenges you face in being a psychologist?
D: I never had big issues with a job and my hearing before. This is the first instance where they did not work with me and as a result, I am losing my job and lost confidence in my skills.”

D6.3 Doesn’t give in-depth responses
“I: If you can, please tell me about a countertransference reaction (a feeling you had) regarding your deafness/hearing loss in response to a client’s comment or action?
D: A client hasn’t really said anything specific.”
[This question may not fit her so well as she works from CBT perspective?]
D6.4 Does not respond to interviewers attempts to connect
“I: What it’s like for you to be in between both worlds? That sounds like it could be frustrating...?”
“D: Yes.”
[Maybe she experiences my desire to connect as insincere?]

D6.5 Seems guarded/defensive?
“In a negative way, I think this postdoc has pushed me backwards as they are very critical of my work and have taken experiences away from me.”
[In turn, she has become critical herself. This sounds like a frustrating experience, especially right at the beginning of her post-PhD career.]

“I’m assuming your goal for the research is seeing how my disability may impact my work with hearing populations but I also see problems with the deaf community because I’m not ‘deaf enough.’”
[I feel appreciative that she is able to point out other areas for potential research.]

D7. Interviewer feels anxious
“I had already been called ‘defensive’ when trying to explain my point of view so I did not feel safe to share my thoughts freely.”
[Is she experiencing the same dynamic with me?]
Interpretive Phenomenological Analysis  
Participant Themes with Excerpts from Transcript  
“Ellen” (Google Chat)

Super-ordinate themes shown in **bold and underlined**  
Working themes shown in **underline**  
Working implicit themes shown in *italics*  
Textual support cut and pasted from transcript  
[Thoughts about theme in brackets]

**E1. Response to Challenges: Does not personalize**  
“One woman was a paranoid schizophrenic with delusions and very concrete thinking so I did not take her rejection personally because it seemed to fit with her symptom pattern, she latched onto my hearing as a reason I would not be able to understand her because I couldn’t ‘hear’ her.”

**E2. Graduate School Support: Seems to have been largely supportive?**  
“They check-in to see how it’s affecting my work from time to time but it doesn’t appear to lessen their confidence in my work at all, generally they have been quite supportive.”

**E3. Positive Impact of Disability on Therapy Career**  
“I think [my disability] may actually enhance the alliance at times with some kids who have trust issues with adults; while there are moments of frustration when I miss something a child has said that they need to repeat they are usually okay, and other times they have curiosity and questions about my hearing loss.”

**E4. Positive Outlook with Respect to Disability**  
“Lipreading with kids can be challenging for sure but I’ve been lucky to help them understand I need to see their faces when they are talking.”  
[When she presents a challenge she finishes off on a positive note – coping skill?]

**E5: Depression as both positive and negative? Serves multiple role in her work with clients.**  
“[Disability] contributed to my depression and also to being a keen ‘observer’ of other people.”

**E6: Self-Disclosure Process: Straightforward**  
“Mostly I make a point of telling folks right off the bat to make sure I can see them when they speak, and put them at ease to feel free to ask questions about my hearing loss, but without taking the focus away from their issues to me too much.”  
[She works to put kids at ease by self-disclosing; wonder how it’s different with adult clients?]

**E7: Patient Reactions to Disclosure**  
“I did have a couple adult clients who felt I couldn’t ‘hear’ them (literally and figuratively I suppose) and one child whose guardian was uncomfortable for whatever reason with my hearing loss, but 3 people out of several years of practice is not too bad ;)”  
[Again, she ends on a positive note – is she trying to reassure me? With the smiley face? What makes 3 not a bad number?]
E8: Use of Disability to Psychoeducate

“But I feel that's beneficial if kids that feel ‘different’ due to whatever circumstances brought them to therapy find they can talk to an adult who has been through some challenges and overcome them.”