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Experience of Established Mental Health Counselors Working with Adults who have Intellectual Disabilities

Margarete Denk
Walden University

Walden University

College of Social and Behavioral Health

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Margarete Denk

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Review Committee
Dr. Julia Champe, Committee Chairperson, Counselor Education and Supervision Faculty
Dr. DeAnna Wilson, Committee Member, Counselor Education and Supervision Faculty
Dr. Rebecca Cowan, University Reviewer, Counselor Education and Supervision Faculty

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Walden University
2023

Abstract

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Margarete Denk

MS, Capella University, 2007

BS, Georgia Southern University, 2001

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Counselor Education and Supervision
Forensic Mental Health Counseling Specialization

Walden University
May 2023

Abstract

Individuals with disabilities make up the largest minority population in the United States. Individuals with intellectual and developmental disabilities (I/DD) make up a significant portion of this population, yet there are limited studies addressing counseling with the I/DD population. The Council for Accreditation of Counseling and Related Educational Programs has addressed the need for disability competence in their upcoming 2024 standards. The purpose of the phenomenological study was to describe lived experiences of established counselors working with adult clients diagnosed with an I/DD. A descriptive phenomenological approach was used along with the social model of disability. The study involved six participants. Although eight interviews were conducted, two participants were deemed ineligible for the study despite having successfully gone through the screening process. Giorgi's data analysis method was used to code participant data. Thematic development resulted in five primary themes across participants: competence, joining, comparing, regard, and encouraging. Results of the study confirm the need for increased disability competence among mental health professionals which may help inform training and continuing education for established counselors. The study included concrete examples of lived experiences of counselors working with clients who had I/DD that can be used to enhance mental health counseling for this client population.

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Dedication

To my sweet baby boy, Jay, I would have never kept trying and would have given up long ago if it were not for you. You have been my biggest cheerleader and greatest source of support throughout this entire process. Watching you fight for your life as you battled leukemia twice over the last nine years made my biggest challenges seem like nothing. You do not know life without me in graduate school. I am so excited for the next chapter of our lives to start. Doctoral degree notwithstanding, being your mother has been the greatest achievement of my life. Most. More. Possible.

I also dedicated this work to In Memoriam to my mother, Karyn Denk Walker, and my grandparents, Major Edgar H. Denk, Jr. and Margarete Denk. Their love and support are never far from me. I know there was one hell of party up in Heaven the day I finally finished this thing. I have no doubt they were with me every step of the way.

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Finally, to my friends and family, especially my family at VFW Post 8087, thank you for unwavering support and for believing in me even when I didn't believe in myself. The end is written, the work it finished. So mote it be.

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Chapter 1: Introduction to the Study

Individuals with disabilities make up the largest minority population in the United States (U.S.), with nearly 7% of children diagnosed with a developmental disability and approximately 1% of the U.S. population living with a diagnosed intellectual disability (Centers for Disease Control [CDC], 2017). Despite this high prevalence, disability competence is low and counselors are largely unprepared to work with this population (Rivas, 2017; Rivas & Hill, 2018; Strike et al., 2004). There is a need to examine experiences of counselors working with clients who have intellectual and developmental disabilities. In this chapter, an overview of the study is presented. The history of mental health treatment for individuals with disabilities, training and supervision of counselors to work with clients who have intellectual disabilities, contributions of the field of rehabilitation counseling, and concepts related to the phenomenological research method are discussed. The purpose of the study is presented, along with the theoretical foundation and conceptual framework, research questions, limitations, delimitations, and assumptions of the study. A list of definitions of terms is presented. The chapter concludes with the significance of the study.

Background of the Study

Individuals with disabilities are the largest minority group in the U.S. (Artman & Daniels, 2010). The terms intellectual disability and developmental disability or delay are often used interchangeably in the literature with minor nuances as to the operational definitions; intellectual disabilities always fall under the umbrella of developmental disabilities but occasionally, a developmental delay may not lead to a lifelong disability (Centers for Disease Control and Prevention, [CDC] 2015). The Diagnostic and Statistical Manual of Mental Disorders [DSM-5-TR], 2022) defined intellectual or developmental disabilities as deficits in individual intellectual functioning in terms of problem solving, academics, and/or learning from experience, and those deficits impair their ability to communicate, live independently, and/or perform tasks involving daily living (American Psychiatric Association [APA], 2022). According to the CDC (2015), developmental disabilities are a varied group of disabilities that impact major life activities, including language learning, often making independent living difficult. Developmental disabilities include attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), intellectual disabilities such as Down syndrome, learning disorders, and moderate to severe vision and hearing impairments (CDC, 2015).

The US Department of Health and Human Services (DHHS, 2015) reported that in 2014, an estimated 2.24% of U.S. children had some form of ASD, 3.57% of children had a developmental delay (DD), and an additional 1.10% of children had an intellectual disability (ID), making the total combined prevalence of overall developmental disability 5.75% of all U.S. children. The U.S. DHHS (2015) noted statistics were based on surveys of children living in home; children living in institutionalized environments were not included, and the prevalence of developmental disabilities is likely higher. The CDC (2015) reported the prevalence of developmental disability was 13.87%, or approximately one in six children living in the United States. Boyle et al. (2014) reported nearly 14% of children in the U.S. having a developmental disability. The CDC (2015) reported over a 17% increase in the prevalence of developmental disabilities between 1997 and 2008; that increase means 1.8 million more children diagnosed with developmental disabilities in 11 years. Autism had the highest increase of all developmental disabilities, with an increase of nearly 300% (CDC, 2015).

While the DSM-V-TR defines intellectual developmental disorders as deficits in an individual's intellectual functioning in areas such as problem solving, academics, and/or learning from experience, and those deficits impair the person's ability to communicate, live independently, and/or perform tasks of daily living (American Psychiatric Association, 2022).The term intellectual/developmental disability (I/DD) is used throughout the study to describe the target clinical population. Differences between the terms intellectual disability and developmental disability are slight, with developmental disabilities including intellectual disabilities and also physical disabilities that occur prior to age of 22 (National Institutes of Health [NIH], 2018). While significant for some research and literature, the nuances between the terms are not enough to differentiate in the current study and the term I/DD will be used except in circumstances where authors use specific terms. It should also be noted that these terms are frequently used interchangeably within literature.

When working with individuals who have I/DD, counselors face important issues involving lack of conceptual models of disability and lack of education and research with people who have developmental disabilities (Boyle et al., 2011). Boyle et al. (2011)

suggested individuals with I/DD presented unique challenges for counselors, involving conceptualization of disability and gaps in education and research. Little exists in counseling research to guide counselors to address mental health needs of clients who have I/DD. Woo et al. (2016) found that just over 1% (29 out of 2,591) of articles published in the main American Counseling Association journals between 2003 and 2013 focused on disabilities. Of those 29 articles, approximately half were focused on intellectual or developmental disabilities; two of those articles were published in the *Journal of Counselor Education and Supervision* (Woo et al., 2016). Counselors who work with clients who have I/DD require adequate tools to work with this population; these include education and training specific to individuals with I/DD. While rehabilitation counseling literature promotes and advances disability competence for practitioners across disciplines, mental health counseling literature is largely devoid of discussions involving disability competence among counselors. The merger between accrediting bodies for counseling and rehabilitation counseling will significantly change the curriculum and training in Council for Accreditation of Counseling and Related Educational Programs (CACREP)-accredited programs, expanding counselor professional identity and competencies for all counseling specializations (CACREP, 2020). Updated 2023 CACREP standards add disability content to core standards.

Currently, there is a degree of discord between the work of clinical rehabilitation counselors and mental health counselors; while both professions have their own identity, there needs to be a shared goal of providing services to all clients, including those with

I/DD. Both sides acknowledge the dearth of literature regarding disability competence among mental health professionals (Evans, 2017; Rivas, 2017). It is the goal of the current study to lessen that gap. Evidence of this gap is based, in part, on the findings of Foley-Nicpon and Lee (2012) where between one and three percent of all articles published within the field of counseling psychology in the five major journals over the last twenty years focused on disabilities.

Because individuals with disabilities form the largest minority group in the United States (Artman & Daniels, 2010) it is important that all mental health professionals have a degree of disability competence. More than one in ten children in the United States have an intellectual disability (Boyle et al, 2011). Given these statistics, it is likely that a counselor will encounter multiple clients with I/DD across their career. There is a positive correlation between self-efficacy and course work, internship hours, and counseling-related field experience (Goreczny, et al., 2013) suggesting that newly trained counselors need to have experience working with specific populations in order to develop the self-efficacy necessary for effective clinical practice. Little exists in the literature discussing the experience of counselors working with clients that have I/DD; exploration into this experience is therefore warranted to understand the phenomenon of working with clients that have intellectual disabilities. Before concepts such as training, supervision, and self-efficacy can be adequately discussed, the experience of counselors working with clients that have I/DD must be first examined.

Problem Statement

Despite the prevalence of I/DD, there is a lack of understanding of what it is like for counselors to work with this population. Little exists within the counseling literature on working with clients who have disabilities and even less exists on working with clients who have I/DD. Given the overwhelming lack of literature from the mental health counseling and counselor education literature (Artman & Daniels, 2010; Rivas, 2017; Rivas & Hill, 2018; Woo et al., 2016), related fields such as counseling psychology and school counseling must also be examined for their inclusion of disability research (Cimsir & Carney, 2017; Evans, 2017; Goodman-Scott et al., 2019; Shell, 2020). It is also imperative that the rehabilitation counseling literature be examined for its contribution to disability literature (Evans, 2017; Forber-Pratt, et al., 2018; Huber, et al., 2017; Rumrill, et al., 2019).

Over one quarter of the United States population has some type of disability (Center for Disease Control and Prevention, 2019). Additionally, nearly 14% of children in the United States receive special education services though the Individuals with Disabilities in Education Act (United States Department of Education, 2018). While almost always diagnosed in childhood, I/DD is a lifelong diagnosis and continues to affect individuals into adulthood. Given these statistics, it is likely that a counselor will encounter multiple clients with I/DD across their career, yet the current Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) makes no specific recommendations that student mental health counselors receive specific training for working with individuals that have disabilities.

CACREP (2016) cites the importance of trauma in counseling and requiring that CACREP accredited programs educate students about the impact of trauma on individuals. CACREP (2016) also cites the importance of cultural competencies among counselors but does not specifically mention individuals with I/DD as a special population. While there is much attention given to certain aspects of multiculturalism such as race, religious beliefs, sexual orientation, and socioeconomic status in the education of counselors, there is little attention paid to developmental disabilities (Weiss, et al., 2010). Pope (2014) stated that it is the responsibility of higher learning institutions to prepare counseling students to work with a wide range of clients without their own beliefs or values getting in the way of the counseling process. Individuals with I/DD should be considered a cultural class based on their need for unique attention within the research and in counseling practice (Campbell, 2002; Peterson & Elliott, 2008). Collins, et al. (2015) cite the importance of considering the unique worldview of clients and suggest that failing to recognize a client’s cultural identity can be harmful in the therapeutic process.

The CACREP (2016) standard for counselor education is a 60 semester-hour training program that also includes both a practicum and internship. In July of 2015, The Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the Council on Rehabilitation Education (CORE) announced plans for a merger that would unite the organizations under the umbrella of CACREP (CACREP, July 2015). This merger suggests that CACREP has recognized the need to infuse disability awareness and education into counselor education programs; the 2023 CACREP standards will reflect these recommendations.

Currently, CACREP has standards for Clinical Rehabilitation Counselors as a specialty within Counselor Education. These standards exist within the context of voluntary specialization that include other areas, such as addiction counseling and marriage and family therapy (CACREP, 2016). The 2023 CACREP Revision Committee (CACREP, 2020) has been charged with infusing disability concepts into each of the eight core curricular areas within counselor education programs (Profession Counseling Orientation and Ethical Practice; Social and Cultural Diversity; Human Growth and Development; Career Development; Counseling and Helping Relationships; Group Work; Assessment and Testing; Research and Program Evaluation). The infusion of disability concepts into each of these areas within counselor education creates the opportunity for the development of disability competence among all counselors, not only those who chose a specialty in Clinical Rehabilitation Counseling.

The majority of the counseling disability literature was created in the 1990s when multiculturalism was a major focus of the research (Carney & Cobia, 1994; Korinek & Prillman 1992; Middleton, et al., 1999). While that research did advance the literature, it did little to advance clinical practice (Oliver, 2013). Rivas and Hill (2018) further highlight the current gap in the literature, reporting that despite having coursework and training in multicultural concepts, counseling students did not feel prepared to work with clients who have disabilities. The merger of the rehabilitation counseling and mental health counseling accrediting bodies, as well as the addition of disability concepts to the 2023 CACREP Standards, highlight the acknowledgment of the need to train counselors to work with clients who have I/DD. Counselors trained prior to these additions also need to be prepared to work with this population. The current study seeks to gain insight into the adaptations counselors make when working with clients who have I/DD.

Gap in the Literature

The literature provides little information about working with individuals with intellectual disabilities in counseling and the counseling literature underrepresent individuals with disabilities more than any other minority group (Artman & Daniels, 2010). Corbett (2011) stated that the psychotherapy profession purposefully excluded those clients with intellectual disabilities. It should be noted that while Corbett (2011) makes broad accusations against the psychotherapy community, the article was published in *Psychodynamic Practice: Individuals, Groups, and Organizations* and not a journal of the American Counseling Association. The journal was formerly titled *Psychodynamic Counseling* (1994-2001) and does focus on therapeutic counseling. Corbett (2011) does not bring up issues only within the psychotherapy community, but society at large, stating that solutions to the issues must begin within the psychosocial community. The gravity of Corbett's (2011) position on the exclusion of clients that have I/DD cannot be ignored by the mental health community.

Two articles citing content analysis of disability research highlight the overwhelming lack of disability research in counseling and psychology (Foley-Nicpon & Lee, 2012; Woo, et al., 2016). Foley-Nicpon and Lee (2012) found much of the disability literature relates to the school system and school psychology and often references counseling psychology; while a distinctly different discipline from mental health counseling, there is much to be learned from this counseling specialty as it pertains to mental health counseling (Fabian, et al., 1998; Levinson, 1994; Noonan, et al., 2004). There is also a concentration of articles written in the mid-2000s following the 2004 Individuals with Disabilities Education Improvement Act (IDEA, 2004).

Foley-Nicpon and Lee (2012) analyzed five major psychology and counseling journals *(Journal of Counseling & Development, Journal of Counseling Psychology, The Counseling Psychologist, Journal of Multicultural Counseling and Development, and Cultural Diversity and Ethnic Minority Psychology*) from 1990 through 2010. It should be noted that while Foley-Nicpon and Lee (2012) use the term “counseling psychology” throughout their article, the *Journal of Counseling and Development* and the *Journal of Multicultural Counseling and Development* are both journals of the American Counseling Association. Within the five journals, one percent of the overall publications included disability concepts over the past 20 years; of the thousands of articles published, 55 related to disability concepts (Foley-Nicpon & Lee, 2012). The major conclusions to come from the article were the increased need for disability research and for disability concepts to be more prominent in counseling psychology coursework and practicum experiences (Foley-Nicpon & Lee, 2012).

Woo et al. (2016) conducted a ten-year content analysis on American Counseling Association journals and found that just over one percent (1.1%) of articles published between 2003 and 2013 met their inclusion criteria for disability-focused research. Woo, Goo, and Lee (2016) concluded from their findings that counseling researchers were less likely to focus on disability-related topics than other counseling topics. Notable for the counselor education profession, there were zero articles published in Counseling and Education journal related to disability in the ten-year time frame (Woo, et al., 2016).

The National Association for the Dual Diagnosed has published a journal, the *Journal of Mental Health Research in Intellectual Disabilities* since 2008. During that time, 782 articles have been published; two articles addressed counselor education and one of those two articles addressed self-efficacy (Viecili, et al., 2010).

Artman and Daniels (2010) argued that the mental health professionals as a whole have not adequately attended to the needs of individuals with disabilities within the research or in the education of counseling professionals. While the article was published in *Professional Psychology: Research and Practice*, Artman and Daniels (2010) frequently refer to “psychotherapists” and “psychotherapy”, although directed at psychologists, they are terms also associated with the counseling profession. However, the article remains applicable to the current study in the context of mental health. Artman and Daniels (2010) suggest a move away from the historical conceptualization of emotional distress as being directly tied to coping with one’s disability but rather include those factors as one of many reasons why a person with a disability may have mental health concerns. The authors suggest disability be conceptualized in the same manner as other multicultural issues and that interventions be designed appropriately. Cultural competencies in the areas of skill development, accessibility, client recruitment, scheduling, psychotherapy milieu, testing, and advocacy are all suggested (Artman & Daniels, 2010). Interestingly, there are few citations in the discussion of these suggestions of cultural competencies when working with people that have disabilities, further highlighting the lacking body of literature when working with this population.

Based on the analyses of Woo, et al. (2016) and the work of Artman and Daniels (2010) it is clear that disability research is missing from the counseling literature. Counseling and psychology focusing primarily on interventions for individuals with disabilities has historically been left to the field of rehabilitation counseling (Artman & Daniels, 2010; Corbett, 2011). The accrediting bodies of counselor education (Council for Accreditation of Counseling and Related Educational Programs) and rehabilitation counseling (Council on Rehabilitation Education) took notice of this disparity and the merger of CACREP and CORE occurred in July of 2017 (CACREP, 2017).

The merger of the CACREP and CORE accreditation bodies suggests that there is consensus in the need to educate and train counselors to work with clients that have intellectual disabilities. Much like the lack of literature on counseling individuals with disabilities, there is an underwhelming amount literature and little attention paid to I/DD within the CACREP standards; a PsychINFO search yielded zero results for the terms “CACREP” and “intellectual disability”. Several articles attending to disability issues within CACREP programs when “intellectual disability” was expanded to “disability” (Feather & Carlson, 2018; Oksuz & Brubaker, 2020). Additional articles peripherally related to general disability were also present in that search (Shin, et al., 2011; Sprong, et al., 2018).

The lack of literature on working with clients that have I/DD supports the notion that there is a lack of understanding into the experience of counselors working with this population. The literature (Evans, 2017; Rivas, 2017; Feather & Carlson, 2018; Rivas & Hill, 2018; Deroche, et al., 2020; Oksuz & Brubaker, 2020) supports the fact that counselors are not educated to work with the I/DD population, despite the prevalence of I/DD in the population. Therefore, the question must be asked: what is the experience of counselors when working with clients who have intellectual or developmental disabilities?

A study conducted by Rivas and Hill (2018) and found that multicultural training had an impact on the way counseling interns experienced working with clients that had disabilities. Specifically, multicultural training offered inconsistent exposure to disability and was presented alone or was absent in their coursework (Rivas & Hill, 2018). While Rivas and Hill (2018) focused on the multicultural training aspect and how that informed the counselor trainees in their study, the current study seeks to understand the lived experience of counselors that have already graduated and where their perceived competence to work with clients that have intellectual disabilities came from. Rivas and Hill (2018) found that counselor trainees did not feel fully prepared to work with clients that have disabilities through their coursework and internship process. Where, then, do counselors gain proficiency and self-efficacy for working with this population? What happens post licensure when training and supervision are complete? The starting place to answer these questions is what is the experience of counselors working with clients that have I/DD?

Purpose of the Study

The purpose of the study is to understand the experience of established counselors working with adult clients that have I/DD. Gaining insight and understanding into the experience of counselors working with this population can help to shape future research and influence the training and supervision of future counselors. It is crucial that mental health counselors have disability competence so they can effectively provide treatment interventions to this population. It is equally important that rehabilitation counselors have clinical counseling competence when working with the disability community. By understanding where and how these competencies are developed, more effective services can be provided to the I/DD community.

The objective of the current study is to determine the experience of counselors working with clients that have I/DD, but who do not have a specific focus or specialty working with the disability community. The insight and understanding that will come from examining the unique lived experience of counselors working with this population can then be used to inform not only the literature but the manner in which future counselors are educated. This can then potentially improve the counseling services that are available to individuals with I/DD. The focus of the current study is clinical mental health counselors who did not specialize in other areas of counseling, including clinical rehabilitation counseling. This will benefit established clinical mental health counselors who did not have disability addressed in the educational programs. Future mental health counselors will have disability infused into all aspects of their education under the 2023 CACREP standards. The benefit to the disability community may also be substantial as understanding the experience of counselors working with this population can lead to positive changes in services and service delivery.

Research Questions

RQ1: What are experiences of established counselors when working with clients who have intellectual or developmental disabilities?

RQ2: How do counselors adapt their counseling practices to work with clients with I/DD?

RQ3: What are influences on disability competence for established mental health counselors?

Conceptual Framework

The conceptual framework for the current study was descriptive phenomenology (Giorgi, 2006) through the lenses of the Social Model of Disability (SMD) (Oliver, 2013) while considering multicultural implications as well as counselor preparation and preparedness. That is to say that a phenomenological perspective (Giorgi) will guide the research while attention will be paid to the SMD (Oliver, 2013) and multiculturalism (Rivas, 2017) as it influences the nature of the research. Phenomenological research takes a big-picture view of data collection that examines what it being studied from a holistic perspective (Giorgi, 2012). The social model of disability provides a framework from which to conceptualize the needs of clients and the work of counselors with this population. This model provides counselors with the necessary space to advocate for the needs of their clients. Historically, the medical model of disability viewed disability as a problem; an issue that needed to be cured or fixed (Swain, et al., 2003). The social model of disability also recognizes the restrictions placed on individuals and advocates for social change (Oliver, 2013). This model allows counselors to work with clients who have I/DD in such a way that they can move past societal constructs and restrictions and empower their clients.

Regarding counselor preparedness and preparation, there needs to be an andragogical approach to educating future counselors to work with clients who have I/DD. Future counselors will learn what they are presented with through the experiences that are afforded to them. It is crucial then that counselors are exposed to disability theories and concepts. The social learning theory is the idea that people learn by watching others and the environment. Self-efficacy is a major tenet of the social learning theory and basis for the social cognitive model of counselor training (Larson, 1998). Self-efficacy is part of the social learning theory and is an individual’s beliefs about their ability to accomplish a given task or goal (Bandura, 1977). Self-efficacy among counselors can be conceptualized as their beliefs or judgments about their ability to effectively provide therapeutic interventions to clients (Larson & Daniels, 1998).

Little is known about experiences of counselors working with clients that have I/DD; the current study involved closing gap regarding working with clients who have I/DD. There is a need to explore, understand, and conceptualize experiences counselors have when working with this population so that counselor education can appropriately train future counselors to work with this population.

Theoretical Framework

A main tenant of the phenomenological research method is the suspension of judgment, bias, and previous knowledge about the phenomena being studied (Giorgi). While the conceptual and theoretical frameworks for the current study shaped the ideas and development of my work, they must be set aside when analyzing the data in order to truly create a phenomenological study (Peoples, 2021). For the purpose of fully understanding the perspective of this researcher, the theoretical and conceptual basis for the current study are discussed in further detail in Chapter 2.

Phenomenological research is a holistic approach to data collection that looks at the whole picture of what is being studied and seeks to capture the essence of an experience when little else is known about that experience (Giorgi, 2012). Based on the philosophical work of Edmund Husserl, phenomenological research holds a primary tenant of eliminating all assumptions when studying a particular phenomenon (Peoples, 2021). The question of the experience of established mental health counselors when working with clients who have intellectual disabilities cannot be answered by the current research and literature. An inquiry into this experience is needed to gain insight and understanding into the unique experiences of the population. Descriptive phenomenological research allows participants to describe in detail their perceptions and experience of the phenomenon (Giorgi, 2012).

Nature of the Study

This study was a descriptive phenomenological study; given the current lacking body of literature on educating counselors to work with clients that have I/DD this is the appropriate approach. It was important to gain insight and understanding into the lived experience counselors have working with this population. Giorgi (2012) stated that when there is the need to explore a specific phenomenon, a phenomenological approach is the appropriate method.

There is a wealth of information on counselor education and the need for specific coursework to develop self-efficacy and competence. (Barden & Greene, 2015; Constantine, 2001; Morris & Minton, 2012). Additionally, there is an extensive body of literature on the unique needs of individuals with I/DD (Boyle, et al., 2001; Vereenooghe & Langdon, 2013; Wilner, 2005). What is lacking, however, is the research to tie the two together. The CACREP/CORE merger describes the need to infuse disability competencies into the counselor education curriculum, so the need to explore newly trained counselors’ experience working with clients that have intellectual disabilities was warranted.

The study sought to explore the experience of counselors’ clinical work with clients that have I/DD and the way resources are adapted to meet the needs of those clients. The ultimate goal of the study is to change the way in which counselors are educated and trained to work with clients that have intellectual disabilities and ultimately improve the services that are offered to this population. A phenomenological approach allows a perspective that takes into account the phenomenon of both experience and behavior while respecting the rigors of the scientific method expected within the scientific community (Giorgi, 2012).

The primary focus of the study was to explore the unique experiences of counselors working with clients who have I/DD. An understanding of that experience can help to shape how counselors are educated to work with clients that have I/DD and ultimately benefit the clients with better therapeutic interventions tailored to their unique needs.

The recruitment strategy for the current study included snowball sampling beginning with professional contacts who are peripherally known to the author who have access to the target population. The author has lived and worked in the same community for the past twenty years and has contacts throughout that community that are expected to provide the necessary sample size. Participants were initially invited to participate via email and social media; a brief description of the study and necessary qualifications was be provided. Potential participants then had a short phone interview to determine final eligibility; there were expected to be between six and ten participants. The final study included six participants. Each of those participants participated in a semi-structured interview. Due to COVID-19 considerations and restrictions, no face-to-face interviews were be conducted. Video and/or telephonic interviews were used and recorded with an external recording device.

Operational Definitions

Operational definitions are an essential part of all research as they give meaning to variables and allow for the accurate replication of a psychological study (Slife, et al., 2016). Operational definitions are used to clarify terms that cannot easily be easily understood or looked up in a dictionary (Walden University, 2021). The current study sought to answer questions about the experience of established counselors working with clients that have intellectual disabilities using Giorgi’s descriptive phenomenological method. The operational definitions are therefore attached to those concepts. In this study, I used the following definitions:

Bracketing: Concept of setting aside what is known about the current phenomenon and evaluating it without past bias (Giorgi 1997; Peoples, 2012). The terms bracketing and epoche are used interchangeably.

Established Mental Health Counselor: Counselor who graduated from a master’s level counselor education program regardless of CACREP accreditation, has been licensed as a mental health counselor for at least 5 years, and has worked with at least one but no more than 20 clients with I/DD.

Free Imaginative Variation: Consideration of a phenomenon being studied from various perspectives without judgment of perspectives as right or wrong (Giorgi, 2012).

Horizon: The moment in phenomenological research when bracketing is not possible because it is happening in the present (Peoples, 2021).

Intellectual Disability: Below average intelligence and life skills development that is identified prior to 18 years of age; impairment in terms of one's general mental abilities that affect everyday life and ability to cope with everyday tasks (APA, 2013).

Phenomenological Reduction: Suspending the known reality to objectively analyze an experience; and set aside biased and preexisting views (Giorgi, 2012).

Psychological Meaning Units: Taking raw data from descriptions of a phenomenon and converting it into groupings that lead to scientific meaning in research (Giorgi, 1997).

Assumptions

Peoples (2021) stated that in phenomenological research assumptions and bias are set aside and therefore have no place in the research. However, as a doctoral student and new researcher I must be aware of what my preconceived ideas and biases may be so that they may be properly set aside in my research. There are multiple areas where assumptions occur within the research, including the nature of reality, the relationship of the researcher, the role of values within the study, the language and process of the research, and the purpose of the research (Summer, 2003). The way I interacted with the data, my values surrounding the topics in the research, and the development of the research of the research process itself all involve assumptions.

Value assumptions are part of the qualitative research narrative and help to shape the social justice impact of the research (Walden University, 2021). Value assumptions are axiological in nature and represent both the values of the researcher and the values reflected in the literature (Walden University, 2021). The primary value assumption in the current study is that there are fundamental differences in the experiences of counselors working with clients that have I/DD as compared to those clients that do not. An additional value assumption is that individuals with I/DD have emotional, social, and relational problems that can be addressed in the counseling environment. Individuals with I/DD have similar issues than those individuals without disabilities that would reasonably cause them to seek counseling services, however there may be barriers to those services. The assumption of purpose in the current study was to understand the phenomenon of established counselors working with a limited number of clients who have I/DD.

Qualitative research is an inherently hands-on process that requires the researcher to interact with the research (Summer, 2003). I separated myself from preconceived ideas and biases as I conducted the research. Further assumptions that come from the nature of reality and the relationship of the researcher included that the participants would provide accurate information about their experiences working with clients that have I/DD and accurately represented their experience. It was also be assumed that the information provided by participants was unique to their own experience and therefore may not be transferable to other counselors.

Peoples (2021) stated that in phenomenological research, assumptions and biases are set aside and therefore have no place in research. As a doctoral student and new researcher, I must be aware of what my preconceived ideas and biases may be so that they may be properly set aside in my research.

Value assumptions are part of qualitative research and help to shape the social justice aspect of research (Walden University, 2021). Value assumptions are axiological in nature and represent both the values of the researcher as well as values reflected in literature. I assumed there were fundamental differences in terms of experiences of counselors working with clients who have I/DD as compared to those clients who did not. I also assumed that participants in this study had emotional, social, and relational problems that could be addressed in counseling environments. My goal was to understand the phenomenon of established counselors working with a limited number of clients who have I/DD.

Scope and Delimitations

The scope and delimitations of a research study are intentionally determined and set forth by the researcher (Peoples, 2021). The scope of the current study was counselors working with clients who have I/DD. Delimitations included the educational background of the counselor, length of time in practice, and number of clients with I/DD.

For the purposes of the current study, only counselors that had at least five years post-licensure experience were considered. Five years post-licensure experience coupled with the requirements for graduation from a mental health counseling master's degree program, and the internship requirements necessary for licensure allowed for confidence that counselors are established within their profession. The goal was to capture a population of counselors who represented the experience and education of counselors at large. Given that disability makes up the largest minority in the United States (Centers for Disease Control, 2017), it is unreasonable to expect that any counselor has zero outside contact with disability. The current study seeks to understand the experience of counselors who do not have significant outside experience or training when working with clients who have I/DD.

Counselors must have graduated from a counseling program. Mental health professionals that graduated from other training programs (e.g. marriage and family therapy and clinical social work) are included in the current study due to the clinical nature of their work. For the purpose of the current study, Clinical Rehabilitation Counselors were not included in order to capture the experience of counselors who do not have the rigorous education and training related to working with clients who have disabilities. School counselors, guidance counselors, and mental health counselors working in any setting exclusively with individuals under the age of 22 were not included in the study; adult clients with ID/D will be the focus of the study. The goal of the current study was to capture the experience of counselors in general counseling settings where there is not an inherently higher number of individuals with disabilities, such as rehabilitation or school counseling. At the age of 22, students with disabilities “age-out” of the education system and so the requirement of clients over the age of 22 removes the possibility of counseling within the school setting. Counselors must also have had experience working with at least one adult client over the age of 22 with a diagnosis of I/DD. Counselors must have worked with at least one but no more than 20 clients with I/DD. The goal of the current study was to capture the experience of established counselors working with clients who have I/DD who do not have extensive experience with disability or intentionally high disability competence.

Qualitative research has long been criticized as being somehow less valid than quantitative research (Creswell, 2007). The qualitative research tradition attaches meaning to human experience and it does not seek to quantify those experiences (Patton, 2015). Validation is a longstanding issue within qualitative research. Lincoln and Guba (1994) discuss validation in terms of credibility, transferability, dependability, and confirmability. The term transferability is used to discuss the ability of the results of a study to be applied to other people/populations (Lincoln & Guba, 1994).

Phenomenological research is focused on the unique experience of the participant, make transferability more of a concern. Transferability is likened to generalizability and the ability of a study’s results to be applied to other populations or contexts (Patton, 2015). The themes in phenomenological research may be able to provide insight into the experience of others but may not be truly transferable (Peoples, 2021). Giorgi (2006) views the phenomenological process as dependent upon the researcher, therefore a study could never truly be replicated or transferred. Giorgi described transferability as the ability of a study to be replicated so that new insights may be added to the inquiry. Giorgi puts a heavy focus on the researcher as research and therefore holds the perspective that not only are studies not able to be replicated but also that member checking is not necessary. Member checking is the process of asking participants to verify the accuracy and credibility, as well as review and potentially offer changes to rough drafts of the researcher's work (Creswell, 2007). This goes against Giorgi's five-step method of analyzing the data, which ends with taking the description of the experience and clarifying and interpreting the raw data from the research (Giorgi, 2006).

Transferability is often limited in qualitative research due to small sample size (Patton, 2015). The current study seeks to build on the work of Evans (2017) and Rivas (2017) by including participants with a different experience base so the findings may offer insight to a new population of counselors. The main factors affecting transferability in the current study are sample size and potential bias within the participant sample. Sample size is a reoccurring limitation within qualitative research because of the time constraints for conducting a large number of in-depth interviews and the required follow-up for each interview (Patton, 2015). This current study aimed to recruit 6-10 participants, which is in line with the recommendations for phenomenological studies (Morse, 1994: Creswell, 2013; Patton, 2015). While in line with quality phenomenological research, it is also understood that 6-10 participants cannot accurately represent the population being studied. It can, however, provide data to inform future research that is of interest to the generalized population of the study (Peoples, 2021).

Limitations

Limitations within qualitative research must be acknowledged, discussed, and planned for a concise and straightforward manner (Peoples, 2021). It is difficult to generalize qualitative research because it examines the unique perspective of individuals (Patton, 2015). The limitation of the current study are discussed.

While I sought to gain insights regarding experiences of counselors as counselors, there may be participants who have knowledge and or training involving I/DD beyond counselor education. Counselors who had careers in fields working with individuals with I/DD prior to pursuing a master's degree in counseling as well as counselors who had personal relationships with individuals with I/DD may have a higher sense of efficacy when working with this population. Their experiences working with clients who have I/DD in the clinical setting would then be impacted by these outside influences. Demographic questions included the participants' personal and professional experience working with clients that have I/DD, as well as any additional training outside of the counselor education program in which they participated.

There was a potential bias involving recruiting participants through other professionals within the community who may be known to me; a peripheral relationship within the community may influence a potential participant. While participants known to me were not intentionally recruited, there was a chance that I was professionally acquainted with potential participants. All participants who were included in the study were immediately assigned a pseudonym to be used for the duration of the study.

Significance of the Study

Counselors are tasked with working with a variety of clients, many of whom have special needs or multi-cultural considerations that must be addressed within the counseling environment (Artman & Daniels, 2010). Swain, et al. (2003) stated that clients that have developmental disabilities have unique needs that can add complexity to the counseling relationship. Counselor education programs must prepare mental health counseling students to work with the unique circumstances of individuals that have developmental disabilities (Swain, et al., 2003). According to Artman and Daniels (2010), the focus of working with clients who have disabilities needs to move from helping clients to cope and adjust to living with a disability to a model of therapy that accommodates the needs of the individual.

Therefore, counselors should be able to work with these clients in an impactful way for the client, focusing on the goals of the client rather than perceived goals based on their disability (Artman & Daniels, 2010). CACREP (2015) has set standards to ensure the consistent and quality education of future counselors; research must explore the attention given to working with clients' that have developmental disabilities. Pope (2014) stated that the ethics of counseling dictate that the needs of the client must come first, and when working with individuals with developmental disabilities, their needs must be fully considered. With all of these factors in mind, the starting place for developing the literature in this area is to first understand the lived experience of counselors working with clients that have I/DD.

Social Change

Walden University places great value on the mission of social change. The Walden University Center for Social Change carries the mission “to be a connective hub that promotes, facilitates, and supports collaborative alliances, action research, and projects that lead to purposeful action for sustainable positive social change” (Walden University, 2021, website). Research often focuses on the need for social change.

Social Justice

There has been an increased expectation that counselors and counselor education programs promote social justice as a core responsibility of the profession (Shin, et al., 2011). Ethically, counselors must work to create a more just and equitable world by advocating for the needs of their clients and of the global community at large (ACA, 2014). Human rights are the underlying basis for social justice and helping professionals must be aware of issues related to the counseling profession and the community at large (Wronka, 2008).

Many counselors and those in the helping professions bring a great of passion with them to the clinical setting; it is crucial to turn that passion into action in the form of social justice and advocacy. Eriksen (1997) stated that advocacy is a primary way that counselors can work on behalf of their clients for social change. Wronka (2008) described the concept of social justice as awareness of the inner self as it is expressed outwardly through the individual’s efforts. Research can be part of that social justice narrative.

Research

Social change can be facilitated by research as it directs the practices within the mental health profession; research can also clarify the need for social change and advocacy. Wronka (1994) discussed a “human rights culture” that begins with education and argues that teaching human rights within psychology and research produces students that support the idea of human rights. Social change is inherently tied to human rights and there is a need to expand the definition of human rights to a more comprehensive conceptualization (Wronka, 1994).

Research can enhance that conceptualization also then furthers social change as more areas are considered within human rights. The fight for social justice and advocacy is not new to the disability community, although many attempts to further the mental health of the disability community have fallen short (Oliver, 2013). My hope for the current study is contribute to the social change necessary to enhance treatment for individuals with I/DD within mental health community.

Advocacy

Marginalized populations are in great need of advocacy efforts (Wronka, 2008). Addressing the needs of individuals with disabilities creates a sense of empowerment that can foster self-esteem and self-worth. According to the American Counseling Association’s Code of Ethics (ACA, 2104), counselors have an obligation to work on behalf of clients that are not in a position to advocate for themselves; this is crucial when working with clients that have intellectual disabilities.

When the needs of a group are identified, it is the responsibility of those in positions of power to implement change. The needs of individuals with intellectual disabilities have been clearly identified and should be addressed when preparing future counselors (Smart & Smart, 2006). It is the responsibility of counselor educators to help students develop their identity in the field, and this requires that they have all the necessary information and resources to develop that identity (Wronka, 2008). Advocacy, adaptations to clinical practice, and disability competence are critical components of social change in the current study.

Advocacy is a crucial piece when moving forward with an action plan for social justice efforts. Eriksen (1997) stated that advocacy is a primary way that counselors can work on behalf of their clients for social change. In the current case, that means counselors acting on behalf of themselves and their colleagues that work with individuals with an intellectual disability. Smart and Smart (2006) discuss the importance of advocacy when working with clients who have disabilities, citing the increased need for advocacy within this population.

The need for advocacy and self-advocacy remains a crucial need within the disability community; this especially important for individuals with I/DD as such disabilities are often hidden (Rumrill, et al., 2019). Forber-Pratt, et al., (2019) cite the need for allyship in addition to advocacy within the disability community. When working with marginalized populations, representation matters. When this representation is not present, it is crucial that strong allyship be present. There is a clear call within the rehabilitation literature for allyship and advocacy (Rumrill, et al., 2019; Forber-Pratt, et al., 2019). Mental health counselors have an obligation to heed that call and develop disability competence as a profession. The current study seeks to contribute to the development of that competence by exploring the experience of mental health counselors working with this population.

Ethical Practice as Social Justice

The American Counseling Association has published guidelines dictating the ethical responsibilities of counselors. According to the ACA Code of Ethics (ACA, 2014), counselors have an obligation to work on behalf of clients that are not in a position to advocate for themselves. The ACA defines advocacy as the “promotion of the well-being of individuals, groups, and the counseling profession within systems and organizations” and states, “advocacy seeks to remove barriers and obstacles that inhibit access, growth, and development” (ACA, 2014, p.5).

People with disabilities are often at the receiving end of discrimination from both individuals and society as a whole. It may be more difficult for people with disabilities to obtain certain services, participate in activities that individuals without disabilities participate in freely, and access medical care that adequately addresses their needs. The American Counseling Association’s Code of Ethics (2014) stated that the overall objective of counselors is to promote the dignity and wellbeing of clients; this concept was so important to the ACA that it is in fact the first tenant of the Code of Ethics. It is especially crucial to promote the wellness of clients with disabilities because there are often underlying barriers to wellness that those with disabilities face. Addressing these unique needs then becomes an issue of social justice and advocacy for counselors working with clients that have disabilities. The Code of Ethics (ACA, 2014) also stated that counselors should advocate on behalf of clients to encourage the growth and development of the client.

Summary

The experience of mental health counselors working with clients who have I/DD must be understood in order to develop the future of disability competence among these counselors. There is limited literature on the interface of disability and counseling (Artman & Daniels, 2010; Rivas, 2017; Rivas & Hill, 2018; Woo, et al., 2016). The rehabilitation counseling literature clarifies the need for mental health counselors to be more prepared to work with clients who have disabilities (Evans, 2017; Forber-Pratt, et al., 2018; Huber, et al., 2017; Rumrill, et al., 2019).

The scope of the current study is licensed mental health counselors working with clients who have I/DD. Limitations are inherent to qualitative research (Peoples, 2021); the current study has limitations in sample size and potential bias from participants. Delimitations in the current study include the educational background of the counselor, length of time in practice, and number of clients with I/DD. The promotion of social justice is valued by both Walden University and the counseling profession (Walden

University, 2021; Wronka, 2008). The primary social justice goal of the current study is advocacy through research.

Chapter 2: Literature Review

The IDEA Act of 1997 set forth the requirement for all public schools to provide educational program to children with disabilities. The school counseling literature from this time reflects the ideas that school counselors were unprepared to effectively work with students with disabilities (Milsom & Akos, 2003; Korinek & Prillman, 1992).

Historically, rehabilitation counselors had the most contact with the disability community; the rehabilitation counseling literature also provided the most insight into working with clients with disabilities (Thomas, et al., 2010). Disability competence for mental health counselors has been largely absent in the literature with only a small body of research focused primarily on school counseling (i.e., Carney & Cobia, 1994; Middleton, et al., 1999).

The literature surrounding disability research in counseling became largely stagnant with little being published until recently (Rivas, 2017; Evans, 2017). This literature suggests that disability competence needs to be a primary focus; there is little known about how counselors develop disability competence and where that competence comes from. What is known suggests that personal disability-related experience and multicultural coursework are primary factors in the development of disability competence (Deroche, et al., 2019; Oksuz & Brubaker, 2020). Research within the last decade suggests the disparity between the need for the disability competence among mental health counselors and research and literature on the topic (Cimsir & Carney, 2017; Rivas & Hill, 2018).

This chapter includes a discussion of the conceptual and theoretical frameworks of this study from a phenomenological perspective. The SMD is discussed as it relates to the current study. The relevant literature in counseling and related field including counselor preparation to work with clients who have I/DD, the historical context of mental health and rehabilitation counseling, and the current trends in the field are also discussed.

Literature Search Strategy

To conduct a thorough and complete review of the literature, a comprehensive literature review strategy was employed. Multiple databases were used to research key concepts related to the study. The Walden University on-line library system was employed as the vehicle for the literature review; psycARTCLES and psycINFO were the two main databases that were used; Academic Search Complete, Walden University's search feature, and Walden University's on-line database of dissertations were also used. Google Scholar was used for key search terms as well. The terms intellectual disability, developmental disability coupled with counseling, counselor education and counselor training were searched.

Those same terms were searched independently, as well as the terms self-efficacy, counselor self-efficacy, and counselor self-efficacy plus intellectual disability were searched. Due to the timespan that the research was conducted, the literature was searched across time to ensure that the most recent literature was reviewed, beginning in 2016 and finishing in 2023.

I achieved saturation after observing repetitive and common themes across articles and journals. The literature review was repeated until saturation was achieved as evidenced by repetitive, common themes across articles and journals, the identification of a pattern of authors' cross-citing one another was identified, and relevant yet limited research was found (Cimsir & Carney, 2017; Deroche, Herlihy, & Lyons, 2019; Oksuz & Brubaker, 2020; Rivas & Hill, 2018). This research also highlights the gap in the literature and only the recent emergence of disability competence among counselors as a topic within the literature.

To fully address the current topic, additional literature was sought on related subjects such as the CACREP-CORE merger and multicultural counseling competencies, and related professions including school counseling, school psychology and rehabilitation counseling.

Conceptual Framework

The conceptual framework for the current study was descriptive phenomenology (Giorgi, 2006) through the lenses of the social model of disability (Oliver, 2013) while considering multicultural implications as well as counselor preparation and preparedness. That is to say that a phenomenological perspective (Giorgi) will guide the research while attention will be paid to the Social Model of Disability (Oliver) and multiculturalism (Rivas, 2017) as it influences the nature of the research. Phenomenological research takes a big-picture view of data collection that examines what it being studied from a holistic perspective (Giorgi, 2012). The social model of disability provides a framework from which to conceptualize the needs of clients and the work of counselors with this population. This model provides counselors with the necessary space to advocate for the needs of their clients. Historically, the medical model of disability viewed disability as a problem; an issue that needed to be cured or fixed (Swain, et al., 2003). The social model of disability also recognizes the restrictions placed on individuals and advocates for social change (Oliver, 2013). This model allows counselors to work with clients who have I/DD in such a way that they can move past societal constructs and restrictions and empower their clients.

Regarding counselor preparedness and preparation, there needs to be an andragogical approach to educating future counselors to work with clients who have I/DD. Future counselors will learn what they are presented with and through the experiences that are afforded to them. It is crucial then, that counselors are exposed to disability theory and concepts. Social learning theory is the idea that we learn by watching others and our environment; while a simplified definition, Bandura’s model is the basis for many modern beliefs about behavior. Self-efficacy is a major tenant of social learning theory and the basis for the social cognitive model of counselor training (Larson, 1998). The concept of self-efficacy was first discussed by Bandura as part of social learning theory as an individual’s beliefs about their ability to accomplish a given task or goal (Bandura, 1977). Self-efficacy among counselors can be conceptualized as one’s beliefs or judgments about their ability to effectively provide therapeutic interventions to clients (Larson & Daniels, 1998). Larson and Daniels (1998) discuss the need for efficacy in the clinical setting; there is an expectation of efficacy from professional a counselor. Cultural competence also comes into play within the andrological considerations of counselor development. While multiculturalism has been a main tenet of counselor education, the focus on disability within multiculturalism is minimal (Rivas, 2017).

The current study seeks to close the gap in the dearth of research into working with clients who have I/DD. There is a need to explore, understand, and conceptualize these experiences that counselors have when working with this population. Phenomenological psychological research seeks to capture the essence of an experience when little else is known about that experience. There is decidedly little known about the experience of counselors working with clients that have I/DD. Descriptive phenomenology can identify the essence of an experience by taking the description of that experience, suspending judgment about what is being described and translating the descriptions into data that have psychological meaning (Giorgi 2013, Giorgi, & Morley, 2017).

Social Model of Disability

Models of disability influence the professional relationships and the interaction between professionals and their clients (Smart, 2009). Models of disability also influence the lives of individuals with disabilities, making models of disability especially important. However, despite this importance, models of disability are rarely considered as part of the counseling process. While no single model adequately reflects all the aspects of a person with a disability, professionals must choose a model that best reflects the needs of the individual (Smart, 2009). For the purpose of this study, the social model of disability is used because individuals with disabilities are not viewed as the problem in the model, rather society's reaction to disability is seen as the problem (Oliver, 2013).

The SMD is based on the belief that many of the barriers that people with disabilities face is brought on by the societal norm of living without a disability and that those barriers are created by society (Swain, et al., 2003). The SMD sits in opposition of the medical model that views the disability itself as the issue rather than way the disability is approached, as is true with the social model (Swain, et al., 2003).

Additionally, the social model of disability recognizes the disadvantages and restrictions often placed on individuals with disabilities rather than blaming the disability itself (Swain, et al.). This model allows for counselors to promote social change and allows the individual to control his or her view of disability (Oliver, 2013). This is also most congruent with the views of counseling and a client-centered approach that takes the client perspective into account.

Counselor Preparation and Preparedness

At the very core of my research is the idea that counselors must be trained to work with clients that have intellectual disabilities; this idea is based on that people with disabilities have inherent mental health needs not unlike their non-disabled counterparts. The process of becoming a counselor is a process that includes both education and supervision; this training and supervision, along with the counselor’s own previous experience drives counselor competence. Each of these aspects is equally important in the development of competence as a counselor.

Counselor preparation first involves the educational component of training as theories and techniques are taught and then put into practice. Supervision occurs later in counselor development and builds hands-on skills as real-world experience is gained. Counselor educators and supervisors are charged with the gatekeeping of the counseling profession, ensuring that counselor trainees have the necessary skills to provide effective and ethical services (Lumadue & Duffey, 1999).

Counselor Training

While counselor training varies from institution to institution, the goal is to educate individuals so that they may become competent practitioners. Coursework may initially increase self-efficacy more so than early clinical experience; the literature suggests that self-efficacy is longitudinally increased primarily through clinical experience (Larson & Daniels, 1998). Strike, et al., (2004) reported that professionals with less self-perceived competence had lower levels of disability competence, making self-efficacy a crucial factor in counselor development; self-efficacy is developed through exposure and experience with specific populations.

The American Counseling Association (ACA, 2014) mandated that counselor educators monitor and evaluate the competencies of student counselors to ensure the appropriate level of skill upon completion of a master’s level counseling program.

CACREP (2016) also provided minimum standards to accredited counselor education programs that include ethical and multicultural considerations; The 2023 CACREP Standards infuse disability concepts into all of the core areas of counselor education (CACREP, 2018).

Supervision

Supervision is also a key component of counselor education and also adds to the gatekeeping of the counseling profession (Cashwell & Dooley, 2001). Significant supervision is required in CACREP-accredited counselor education programs (CARCEP). While there are requirements that must be met to qualify as a supervisor, those requirements do not include specific specialization in any one specific area of counseling (CACREP, 2016). Supervision is a crucial component of counselor education programs and is equally as important for newly graduated counselors as they enter their professional careers (Cashwell & Dooley). Cashwell and Dooley reported that supervision must be provided by highly trained and skilled counselors in order to facilitate professional growth. Supervision has a greater impact on self-efficacy when a positive supervision relationship was present, suggesting an ongoing supervisory relationship is key in increasing self-efficacy and counselor growth (Cashwell & Dooley).

Previous Experience

Bandura (1986) stated that previous experience is significantly related to one’s confidence in accomplishing a task successfully and confidence increases self-efficacy. Every counselor will bring with them their past experiences as they enter the counseling profession. Larson and Daniels (1998) stated the importance of experience in the development of self-efficacy. Experiences are positively correlated with self-efficacy in the areas of the specific experiences; mental health professionals with more disability-related experience report higher levels of disability competence than their less experienced peers (Strike et al., 2004).

Cultural Considerations

Cultural competence is well established as a significant tenant in counseling and counselor education with CACREP (2016) emphasizing diversity and multiculturalism in counselor training and ACA (2014) requiring cultural competence standards (Barden & Greene, 2014). Culturalism typically elicits images of diversity among race, religion, ethnicity, and gender. Disability is not often at the forefront of cultural discussions and has been considered its own separate issue away from multiculturalism (Rivas, 2017). Building cultural competencies must include the development of disability competence as a function of culturalism.

Theoretical Framework

Within the phenomenological method, there are multiple approaches that can be taken based upon the varying phenomenological philosophers. There are also differences that exist within the methods that following the teachings of the same philosophers. Husserl is perhaps the most renowned philosopher followed by psychologists and thus has significant impact on the phenomenological research method (Giorgi, 2006).

Phenomenological research was born of Husserl's phenomenological philosophical method. Husserl applied this philosophy to the scientific research method to describe lived human experience (Moran, 2000). While phenomenology is based largely on the present moment, Husserl also acknowledged the influence of past experience and the orientation toward future experiences (Moran, 2000).

After having been exposed to phenomenology as a philosophical approach, Giorgi (2012) set out to develop an interpretation of the method that could be applied to the rigors of psychological research (Giorgi & Giorgi, 2003). The process of the phenomenological research method differ from the philosophical method. Briefly, the very first step in the research method is to get participant descriptions of the phenomenon in question. Subsequently, the researcher then must enter into phenomenological reduction and take on a psychological perspective, analyze the data to determine its essence, and then describe that data on a different level (Giorgi & Giorgi, 2003).

By using phenomenological reduction, the researcher is able to step outside of their bias and present the data in its true essence (Giorgi, 2012). Utilizing a transcendental approach allows participant descriptions to become the focus of the research (Patton, 2015). The descriptive phenomenological method was first use an approach to psychological research by Giorgi (1985) having been developed from the use of phenomenological approach in the study of philosophy. The phenomenological research method is time consuming and meticulous. The researcher is solely responsible for the data produced from the study (Giorgi, 2006).

Giorgi (2006) made two significant changes to his early method; the switch from first person language and discarding redundancies in the transcriptions. Initially, transcripts were transcribed verbatim, keeping first person language. However, Giorgi (2006) changed that to third person later to avoid researcher projection and to maintain the integrity of the participants' experience. The other change came from the manner in which redundancies within transcripts were handled, the switch was made to include those redundancies within transcripts because, while not necessary for a philosophical approach, there is significance of repetition within psychological research (Giorgi, 2006).

Giorgi's (2006) perspective is that while the researcher does need to understand the participants' unique perspective of the phenomenon being studied, it is not necessary to fully enter the participants' worldview. Member checking is not used in Giorgi's descriptive phenomenology. Giorgi argues that participants describe their experience from their unique perspective and not an analytical one. The differences between lived experience and the meaning of that experience are very different; the participant is not always the best judge of the meaning of the experience (Giorgi, 2006). Giorgi argues against such a rigorous and lengthy analysis process when the final data is to be dictated by the participants themselves.

For my study, to stay true to the commitment of capturing the true essence of the experience of the participants it became clear that using Giorgi's method would be the best approach. The focus of the current study is capturing the phenomenon of the experience of established counselors' work with clients who have intellectual disabilities.

While the unique perspective of each participant is important, it is the experience itself that is the focus of the study. To capture the experiences of the participants without interpretation, a transcendental, descriptive phenomenological approach will be used for this exploration of established counselors' experiences counseling individuals with I/DD.

Literature Review

The literature review yielded results that were broken down into subtopics including disability and counselor education, clinical practice with clients who have I/DD, and disability competence. The literature review also specifically addresses the rehabilitation counseling literature as it informs the current study. The major findings from each of the sub-topics are discussed below, as well as a summary of the research as whole. The primary literature that informed the current study are the dissertation works of Rivas (2017) and Evans (2017); their research is discussed at length.

Summary of Disability in Counseling Literature

There is little research on counseling people with disabilities, although there has been an uptick in the literature in very recent years (Evans, 2017; Rivas, 2017, Rivas & Hill, 2018; Deroche, et al., 2019). Summaries of the research on disability (Woo, et al., 2016) and the efficacy of therapies for people with intellectual disabilities (Vereenooghe & Langdon, 2013) are discussed, as well as a review of counselor credentialing and program accreditation (Foster, 2012). These reviews are important in understanding the bigger picture surrounding these topics, as well as providing summary details on a large volume of other research articles.

Woo, et al. (2016) conducted a content analysis of 10 journals published by the American Counseling Association to determine the frequency, type, and nature of the literature pertaining to disability in the counseling field. The study examined articles found in the *Journal of Counseling & Development, The Career Development Quarterly, Journal of College Counseling, Journal of Employment Counseling, Journal of Humanistic Counseling, Journal of Multicultural Counseling and Development, Counselor Education and Supervision, Counseling and Values, Adultspan Journal, and the Journal of Addiction & Offender Counseling* between 2003 and 2013. The authors used an expansive definition of disability for the content analysis; terms as broad as “mobility”, “disorder”, and “disadvantaged” were included in the keyword search. All keywords related to disability as cited in the 2004 Individuals with Disabilities Education Act (IDEA) were also included with the exception of “emotional disturbance” as it was determined to be likely to produce cofounding results. Results included topics related to both physical and intellectual/developmental disabilities. Of the 2,591 articles published in the 10-year period, 29 met the criterion for inclusion in the study. The *Journal of Counseling & Development*, the flagship journal for the American Counseling Association, produced the greatest number of articles with 12 of the 29 coming from that publication. Additionally, of the 29 articles, two focused on counselor preparation and training to work with clients that have disabilities. I found it noteworthy that 17 of the 29 articles were published within three years of the 2004 IDEA. In the same period, the journal Counseling Education and Supervision published two articles related to disability.

Woo, et al. found seven articles published that focused specifically on counseling strategies and interventions.

Despite the increase in the population of individuals with disabilities, there is a lack of representation of disability within the counseling field. As more and more individuals live with disabilities it would be expected that the literature reflect this increase yet, disability has an obvious dearth in the counseling literature. This gap is even more pronounced when considering the literature on intellectual and developmental disabilities alone. Woo, et al. (2016) made specific recommendations toward disability-specific research to enhance the counseling literature.

Historically, there has been an assumption that mental health therapy with individuals with intellectual disabilities is ineffective and there has been little access to psychotherapeutic intervention for this population (Wilner, 2005). This assumption has been challenged and has produced research suggesting the efficacy of psychotherapy in this population (Vereenooghe & Langdon, 2013). Vereenooghe and Langdon (2013) looked specifically at psychological therapies for individuals with intellectual disabilities. Vereenooghe and Langdon (2013) identified 144 research studies published as of 2012 related to the efficacy of mental health treatment in individuals with intellectual disabilities; of those studies, 22 were included based on the specific inclusion and exclusion criteria. The majority of the studies were based on cognitive-behavioral therapy (CBT), while the remaining four were categorized as “other psychological therapies”. Vereenooghe and Langdon (2013) found that psychological therapy is efficacious with people that have intellectual disabilities, specifically CBT, in the treatment of both anger management and depression.

Feather and Carlson (2018) conducted a quantitative study to answer questions about disability coursework and clinical experiences within CACREP-accredited programs, counselor preparedness, integration of disability focused coursework, and its influence on self-perceived competence, and the impact of clinical and personal experience. The participants 141 faculty teaching disability-related content within CACREP-accredited counselor education programs. Only 10% of participants reported that the counselor education program they taught in was “very effective” at addressing the needs of adults with disabilities, while 36% reported that the program they taught in was “ineffective.” Nearly 35% of participants believed that their students were “not at all prepared” or only “a little bit prepared” to work with clients with disabilities. Participants that had previous work with people with disabilities reported significantly more perceived competence than those that did not.

Current Research on Disability in Counseling Literature

Recently, there have been limited yet meaningful contributions to the counseling literature surrounding working with clients who have disabilities (Evans, 2017; Rivas, 2017; Rivas & Hill, 2018). The three recent studies focused on the experience of working with clients who have disabilities and the development of disability competence.

Mental Health Counseling

Rivas (2017) conducted a grounded theory study that sought to create a theory of disability competence among licensed professional counselors. The study examined how counselors develop competence post-licensure to work with clients that have disabilities, how counselors conceptualize disability competence, and in what ways does disability competence differ from multicultural competence. The Rivas (2017) study had 20 participants that engaged in two interviews and two interpretive dialogue interviews in the grounded theory tradition. Rivas (2017) focused on the manner in which licensed counselors develop competence, what that competence looks like for licensed counselors in practice, and the similarities between disability competence and the larger umbrella of multicultural competence. The resulting theory illustrated the influences surrounding the participants' perceptions of the development of disability competence when working with clients who have disabilities.

Rivas' (2017) use of a grounded theory approach was based upon the desire to bring increased attention to the process by which counselors develop disability competence. Grounded theory research is limited in its scope by seeking to create a theory based upon the data collected and has rigid boundaries around already existing theories and knowledge (Creswell, 2018).

Rivas conceptualized disability broadly, including physical, developmental, cognitive, and sensory conditions. Rivas acknowledged that the construct of disability was complex highlighting the disparity between an individual born with a physical disability requiring the use of a wheelchair versus an individual injured as an adult in combat. Rivas included not only all types of physical disability, but all other constructs of disability as well, making the experience of the counselors difficult to categorize and conceptualize.

While this conceptualization is common in the current literature, multiple studies cite the need to narrow the conceptualization of disability, especially between cognitive and physical disability (Goodman-Scott, et al., 2019; Strike, et al., 2004). While the Rivas study contributes to the disability counseling literature and our understanding of how disability counseling competence develops, future research focused on counselors' lived experiences of working with clients with specific disabilities may provide valuable insight into counselor development. By understanding the experience of working with this population, specific training opportunities and experiences can be created for counselors to increase their disability competence. The current study seeks to gain insight into that very experience.

Rivas and Hill (2018) explored the experience of counselor trainees working with clients with disabilities who had received multicultural training within their counselor education program to work with clients who had disabilities. Participants were 10 counseling internship students aged 23-29 years old enrolled in two CACREP accredited counselor education programs. Six of the 10 participants reported taking a specific course on disability. Eight of the participants were enrolled in clinical mental health counseling programs, and one each school counseling and substance abuse counseling programs.

Rivas and Hill sought to understand the experience of counseling interns who received multicultural training to counsel people with disabilities and what it was like for counseling interns to work with clients who have disabilities in their internship practice.

Rivas and Hill (2018) used Moustakas’ (1994) transcendental phenomenological approach, which integrates the researchers’ intuition into the process of interpreting participant experience. The researchers followed Moustakas' (1994) five-step process for the coding and analysis of the data. The researchers engaged in triangulation, member checking, and bracketing to increase the trustworthiness and credibility of the results; bracketing was an especially important aspect of the study as it sets aside researcher bias to capture the lived experience of the participants. Course work, inconsistent exposure, the conceptualization of disability, counseling practice, and emerging reactions were reported as the five themes that impacted counselor trainees working with clients who have disabilities.

Rivas’ and Hill (2018) provided insights regarding lived experiences of counselor trainees and disability competence. Counselor trainees have little to rely on outside of their educational and life experiences; the pedagogical experience is then crucial for counselor development. Rivas and Hill (2018)stated that participants addressed their own realizations of needing to seek outside training to work with clients with disabilities. Participants in the Rivas and Hill (2018) study conceptualized disability as having more physical connotation; a more narrow definition focusing on intellectual and developmental disability may reveal distinctly unique information about how experienced counselors experience working with this population. The participant population opens the door for future study with experienced licensed professional counselors.

Rehabilitation Counseling Research

There have been limited yet significant contributions to the disability research from the field of rehabilitation counseling on the development of disability competence among counselors. Additionally, while Leahy et al. (2009) cited the importance of counseling knowledge among rehabilitation counselors, they acknowledged that it was not the primary focus of rehabilitation counseling; this strengthens the argument for inquiry into the experience of those counselors whose primary focus is counseling.

Evans (2017) conducted dissertation research surrounding mental health counselors' experiences serving clients with intellectual and developmental disabilities. The heuristic phenomenological study had 5 participants with an average of 18 years of experience. The main research question was, "What is the experience of providing mental health counseling to individuals with intellectual and developmental disabilities"? Additional questions explored participants' views on the rewards and consequences of providing such services, the barriers to quality services for clients with intellectual and developmental disabilities, and the resources mental health counselors need to access when providing services to clients within this population. Unanimous themes emerged among all participants surrounding adapting and modifying traditional resources, a lack of training and education to work with clients who have intellectual and developmental disabilities, as well as the need to keep an open mind and meet clients where they are.

Evans (2017) cited the need to explore the policies in place that impact and influence the systemic barriers that prevent people with intellectual and developmental disabilities from accessing productive mental health services.

There are, however, several factors that compromise the findings, including a small number of participants, potentially biased questions, and out-of-date literature support. Qualitative research often has small participant numbers, however in heuristic phenomenological designs, 10-15 participants is the recommended range (Moustakas, 1994). With only 5 participants, Evans' study may not have captured variety of participant experience; best practice within phenomenology suggests more than five participants. While the number of necessary participants varies, Creswell (1998) suggested 5-25 participants and Morse (1994) suggested at least six.

While Evan's (2017) research questions are directed toward mental health counselors, the study is grounded in the Systemic, Ecological Model for Rehabilitation Counseling. Evans' research questions make a number of assumptions and appear to be grounded in viewing the questions through the lens of rehabilitation counseling, as Evans (2017) states the goal of the questions is to "obtain a better understanding of the mental health practitioner's role in the provider system of Henderson's Systemic, Ecological Model of Rehabilitation Counseling" (p. 36). The study often discusses mental health counseling while drawing directly from the rehabilitation counseling literature; one citation in Evans' study comes from a journal published by the American Counseling Association. It is important to understand the experience of mental health counselors viewed through the lens of mental health rather than rehabilitation counseling. The current study seeks to examine mental health counseling practices in the confines of counselor education, training, and preparedness. Much of the literature is also antiquated, and while that is in part due to the lack of research on the topic, more current research does exist (Lund, et al., 2016; Stuntzner & Hartley, 2014; Woo, et al., 2016). Specifically, the work of Woo, et al. (2016) found that of 2,591 articles published in American Counseling Association Journals, only 29 related to disability.

An exploration into the ways counselors adapt traditional resources for use with clients with disabilities and how counselors develop disability competence without formal training and education would contribute significantly to the mental health and rehabilitation counseling literature. The current study seeks to understand the experience of counselors who were trained prior to the addition of disability concepts into the coursework and how they adapt resources. The background of the current researcher is mental health counseling which offers a different perspective than the work of Evans. Mental Health Counseling and Rehabilitation Counseling have fundamental differences in their approaches, including the way in which client needs are conceptualized and the focus of the counseling (Evans, 2017). The lens of the current study is counselor preparedness and training as opposed to Evans’ perspective of a model of rehabilitation counseling. The current study also proposes to use participants that do not have the exposure to disability and the disability community in the same way that Evans’ participants did. In the Evans study all participants had some connection to the disability community, ranging from working in residential treatment centers, to having children with disabilities, to working within the special education system. While it is expected that most individuals have some exposure to the disability community, the current study will seek participants that have not had significant professional contact with the disability community.

While mental health counselors focus largely on clinical practice, rehabilitation counselors focus on many other facets of the individual, such as vocational needs and healthcare systems (Oliver, 2013; Evans, 2017). The current study focuses on the clinical practice of counselors. Leahy et al. (2009) cited the importance of counseling knowledge among rehabilitation counselors, yet state that it is not identified as the most important domain within rehabilitation counseling. Evans (2017) and Rivas (2017) highlight the disparity between rehabilitation and mental health counseling. Evans (2017) claimed mental health counselors are often unwilling or unable to provide mental health counseling to individuals with intellectual and developmental disabilities, and cited the American Counseling Associations Code of Ethics that counselors should not provide services outside their scope of practice. Evans quantified the issues facing individuals with I/DD from a clinical rehabilitation counseling perspective and focuses on the duality of disability and mental health diagnoses. Rivas (2017) focused on the educations and experience of counselors. Despite the contrast in the approach to the issues, both authors had similar research questions. The current study seeks to expand this research and understand how counselors use traditional resources with clients who have I/DD.

Sharing of knowledge between mental health and rehabilitation counseling is vital not only to both professions, but to the clients served by those professions. The CACREP/CORE merger and the addition of disability concepts across the 2023 CACREP Standards well supports this position (CACREP, 2018). Historically, rehabilitation and mental counseling have been seen as two distinct and separate fields, with the changes to accredited and education of mental health counselors as a whole, there is now the opportunity for these two professions to work in a more collaborative manner with common standards in place.

Disability Competence

There is some recent literature brining attention back to the need for disability competence among mental health professionals. Rivas (2017) and Rivas and Hill (2018) focused on disability competence; both works also reference the absence of disability across counselor training and preparation. Strike, et al. (2004) examined disability competence among mental health professionals across disciplines. Looking to the related fields of school and rehabilitation counseling, there is a small body of research that focuses largely on the preparation of counselors to work with clients who have disabilities and how disability competence is developed within the school counseling research (Cimsir & Carney, 2017; Evans, 2017; Goodman-Scott, et al., 2019; Shell, 2020). Sheaffer, et al. (2008) highlighted this disparity within the rehabilitation counseling literature. Feather and Carlson (2018) examined the preparedness of counselor educators to provide disability related content in CACREP accredited counselor education programs.

The professionalization of the counseling profession is a relatively new movement, occurring largely over the past 50 years (Foster, 2012). The education of counselors is then also concept that continues to develop from a pedagogical standpoint. As the profession continues to develop, there will be specialties and subspecialties that are identified that will inevitably require counselor educators to respond.

Strike et al. (2004) summarized the research on disability competence within the mental health professional population. Surveying psychiatrists, psychologists, social workers, career counselors, disability specialists, and other mental health professionals, Strike et al. (2004) asked questions surrounding perceived competence and self-awareness when working with clients with disabilities. The study found that those professionals with more disability-related experience reported higher levels of disability competence than their less experienced peers. Disability competence, while it may be developed in any number of ways, is associated with disability life experience and multicultural course completion (Deroche, et al., 2019).

Strike et al. (2004) suggested future research narrow the definition of disability, as there may be important distinctions between visible and invisible disabilities. The study was also limited in the broad scope of mental health professionals included. The differences among the education and training between professionals, as well as goals for interventions is very broad; a population of mental health counselors would further the counseling research. The researchers concluded with the recommendation for research-based interventions to increase the disability competence among mental health professionals, although direction for these interventions was not provided. The development of disability competence among counselors is needed.

School Counseling

School counseling is a closely related field to professional counseling and school counseling was significantly impacted by the 1990 IDEA. Within the school counseling literature, there is more focus on students with disabilities; it is a reasonable assumption that school counselors will inevitably be exposed to numerous students with disabilities throughout their career. Recently, the school counseling literature has focused on the preparedness of school counselors to work with students who have disabilities.

Cimsir and Carney (2017) interviewed 105 Turkish school counselors. The majority of the participants (80%) had less than nine years of school counseling experience. The study used three survey measures to collect data; a demographic questionnaire, a scale surveying counselor attitudes towards persons with disabilities, and a school counselor preparedness survey. Cimsir and Carney (2017) found that counselors' attitudes toward students with disabilities were positively associated with their perceived level of preparedness, a result congruent with earlier research (Cimsir, 2016). Cimsir (2016) found that the type of training and positive attitudes towards students with disabilities significantly predicted their self-reported preparedness to work with students with disabilities. Cimsir and Carney (2017) found that the school counselors in their study rated themselves between “somewhat prepared” and “prepared” to provide services for students with disabilities.

Cimsir and Carney (2017) found statistical significance only in the correlation between attitude towards students with disabilities and level of perceived preparedness. To assess attitude, the researchers used the Attitudes towards Persons with Disabilities (ATDP) scale; a higher score indicates a more positive attitude toward persons with disabilities. The ATDP asks participants to agree or disagree with statements about persons with disabilities, such as “Physically disabled persons are just as intelligent as non-disabled ones” and “Most disabled people worry a great deal.” While there was a positive association between training, education, and perceived preparedness, the correlation was not significant. The questions then becomes, where does counselor preparedness come from and how is it developed? Cimsir and Carney (2017) suggested further research into the lack of perceived preparedness in school counselors and the development of that preparedness.

While Cimsir and Carney (2017) provided insight into the development of counselor preparedness, by their own acknowledgment, their research failed to provide insight into how that preparedness is developed. School counselors have more of an expectation to work with clients that have disabilities than counselors in other settings, making it important for the counseling profession as a whole to look to school counseling for insight into working with the population. The current study will focus on mental health counselors and their adaptation of resources in clinical practice.

While the current research specifically within mental health counseling is limited, the literature is clear that there is a gap in knowledge of how counselors develop disability competence. The literature is also clear that the future direction of the research must explore this developmental process and the question of where the competence to work with clients who have disabilities comes from must be answered. The experience of counselors working with clients who have disabilities must be examined. As the new CACREP standards are being implemented disability concepts will be infused into all aspects of counselor counselors; counselors trained before this implementation are still in need of disability competence. The current study seeks to understand the experience of established counselors working with clients who have I/DD.

Milsom and Akos (2003) argued that school counselors are not adequately prepared to work with students with disabilities; further stating that the issue had been ongoing for more than 25 years. In their study, Milsom and Akos (2003) examined what actions school counseling programs were taking to prepare students to work with children and adolescents who have disabilities. They examined the types of disability courses, experiences, and content; differences between accredited and non-accredited programs, and differences between course-specific disability content and disability content infused into other courses. The study consisted of 137 participants from 42 different states.

Disability coursework was required in 43% of the school counseling programs surveyed, and there was no significant difference between accredited and non-accredited programs. Milsom and Akos (2003) found that school counselors who had disability content infused into general content and disability-specific courses were better prepared to work with students who had disabilities than those who did not have the disability-specific courses.

While there is more to be done, Milsom and Akos (2003) found that more disability coursework correlated into more preparedness to provide services to students with disabilities. Similarly, Wilner (2005) suggested that there is sufficient data in the literature to support the efficacy of psychological therapies with individuals who have learning disabilities and that those individuals can adequately participate in those therapies.

Korinek and Prillman (1992) reported that despite the changing expectations to work with clients who have disabilities, the preparation of counselors had not changed since the 1970s. The literature suggests that disability is far underrepresented in the research.

Rehabilitation Counseling

Rehabilitation counseling has been the field within the helping professions that has had the most contact with the disability community by the very nature of the profession, as it serves the disability community directly (Oliver, 2013). Rehabilitation counselors focus not only on the mental health needs of clients with disabilities but also on the vocation, social, and advocacy needs of this population (Oliver, 2013). The rehabilitation counseling literature does focus heavily on the mental health needs of clients with disabilities and the often lacking access to mental health counseling among this population (Evans, 2017; Forber-Pratt, et al., 2019; Huber et al., 2018; Leahy, et al., 2009). The rehabilitation counseling literature also offers emerging trends in the field as the nature of disability changes along with the policies that drive access to intervention and treatment (Rumrill, Bellini, & Koch, 2019).

Leahy, et al. (2009) discussed this issue indirectly with their findings that counseling is not one of the most important knowledge domains among rehabilitation counselors. The authors found that while counseling was important, the most important domains were medical, functional, and environmental aspects of disability, as well as caseload management. As the nature of disability changes, it is expected that the services provided to individuals with disabilities will also change. Rumrill et al. (2019) discussed emerging trends within rehabilitation counseling, citing the nature and causes of disability and policy as the primary factors driving change within rehabilitation counseling.

Smart and Smart (2006) stated that counselors must pay particular attention to the conceptualization of disability as part of the client's identity. There cannot be too much emphasis placed on the disability as it is only one aspect of the client, however it cannot be ignored entirely. Smart and Smart implored counselors to attend to the client's self-identity as many individuals with disabilities consider their disability to be a major tenant of their identity and view the disability with pride. The authors provide practical impactions for consideration of the models of disability within counseling practice, such as being aware that each model of disability reduces disability to a single dimension and can be reductionist. Smart and Smart (2006) finished their discussion with implications for the counseling profession that included 12 points to consider which are discussed at length earlier in this chapter. The major theme of the implications are to avoid generalizing disability and avoid the medical model's conceptualization of disability.

Stuntzner and Hartley (2014) discuss the language of disability, adjustment to disability, and provided guidance for counselors working with this population. Language is an important concept in disability, and as is true for many marginalized populations, there are many antiquated terms associated with disability that are considered derogatory. The use of person-first language is often encouraged; however, it should be left to the individual to determine what language is used in reference to them.

The adjustment to a disability may take many forms, as some disabilities are present from birth while others occur later in life; there is also a difference in the adjustment to physical disabilities as compared to intellectual and developmental disabilities. While an important concept in disability, the current study focuses solely on intellectual and developmental disabilities. Stuntzner and Hartley, (2014) acknowledged that many of the suggestions when working with clients that have disabilities are little more than common sense; being mindful that expressed negative experiences are real, consider the effects of labels, treat clients as people not disability, be aware of personal bias and take steps to address that bias, seek effective training and supervision to work with this population.

Culturism

Within counselor education, historically most exposure to disability came in the form of cultural coursework (Deroche et al., 2019). The addition of disability to the major tenants of the CACREP counselor education curriculum will largely change this in the future, but counselors in practice today were trained and educated without this infusion of disability into coursework in place. When considering cultural implications for counseling, it is crucial that disability be part of that conceptualization. There is a strong correlation between cultural counseling competence and multicultural counseling self-efficacy (Barden & Greene, 2015). Barden and Greene (2015) also cited the need for exposure to diversity and individuals with diverse backgrounds in order to facilitate the development of this competence. The needs of specific groups must be examined and understood in order to facilitate cultural competence (Feather, et al., 2017). Another aspect of cultural competence is the need to understand the role of the civil rights movement on the disability movement (Middleton, et al., 1999). Prior to the establishment of the Americans with Disability Act, the greatest gains in disability rights came through the Civil Rights Act, persons with disabilities modeled their effort for rights and equality from the strategies used by African Americans in the 1960s (Middleton, et al., 1999). Middleton, et al. (1999) recommended that counselor educators and administrators actively explore and implement alternative ways to develop multiculturalism and develop a social advocacy model for counselor education. Rawlings and Longhurst (2016) stated that disability should be view as its own unique culture with all the rights afforded to any other culturally diverse group.

The preparation of counselors to work with clients who have disabilities is a crucial piece of counselor development that cannot be overlooked. Artman and Daniels (2010) stated that despite a significant presence of multiculturalism in the literature, disability literature tends to focus on the adjustment to disability rather than helping strategies for this population. They warned that psychology is primarily based on the medical model of disability and evidenced based practices for clients with disabilities are virtually non-existent. The authors stress the importance of exposure to and building relationships with individuals with disabilities as a valuable learning tool for counselors. Artman and Daniels (2010) stressed the need for exposure to individuals with disabilities in order to build competence in working with the population.

The cultural aspect of disability competence is well-represented within the limited literature; Shell (2020) examined the experiences and perspectives of high school counselors working with students who had disabilities. The phenomenological study focused on the disproportionality of African American students within the special education system and used purposeful criterion sampling to recruit participants. The study was conducted as a two-interview phenomenological design that used purposeful sampling to recruit twelve initial participants, 8 of whom completed both interviews and were included in the results of the study. The participants ranged between 30 and 60 years old with between 7 and 14 years of experience as school counselors. The participants identified as 50% African American and 50% White, working in a range of urban, suburban, and rural school districts.

Shell (2020) used Moustakas' (1994) tradition of phenomenology to conduct the study and analyze data (Shell, 2020). Shell (2020) reported using bracketing, member checking, and triangulation with school district data, among other techniques, to ensure trustworthiness within the data. Participants were also provided a copy of their interview transcripts and the themes identified by the research team for member checking, allowing the participants to comment on the accuracy of the interpretations.

Three themes were identified in the analysis of participant interviews; Dis-regard, separate worlds, and professional knowledge. Dis-regard related directly to the multi-cultural aspects of the study and found that the experience of the participants was to treat all students equally and disregard race and other multicultural factors. The participants also reported significant constraints on their roles and feelings as if they operated in separate worlds. All of the school counselors in the study reported dissatisfaction with their training and preparation to work with African American students who had learning disabilities or difficulties. Each of the participants had different professional experiences prior to becoming school counselors that they reported translated well into their school counseling practices. All of the participants also recognized the need for more education or training for school counselors when working with African American students with learning disabilities and those students receiving special education services; while multicultural training was present in each of their training programs, it was agreed that supplemental training would be beneficial.

Implications and Future Direction

The review of the current research literature revealed little directly related to the current topic of the experience of counselors with clients who have disabilities. Additional literature in related fields of mental health counselor training and practice exists in rehabilitation counseling, school counseling, and counselor instructor training. The future direction from the current literature is clear; more information is needed on the development of disability competence among counselors from all disciplines. Much of the current literature focuses on the polarization of participants with little or extensive experience; many participants had either extensive experience or were new to counseling practice. The focus then needs to shift to exploring disability competence among more generalized professionals; those that are established in the field but who have had little exposure to the disability community.

Rivas (2017) stated that there was a need for enhanced representation of disability and enhanced counselor awareness in counselor education programs and outlined a multi-step approach to enhance disability concepts in counselor education. In professional practice, Rivas suggested the need for a more flexible approach to counseling clients with disabilities and the need for advocacy of this population. Rivas and Hill (2018) made recommendations for future research into the ways in which counselors develop disability competence; specifically advocating for research into the development of disability competence across a counselor’s career. Rivas and Hill (2018) also provide future direction for a content analysis of counselor education programs to examine the disability content in training programs and the manner in which that content was being provided within the program.

Goodman-Scott et al. (2019) reported the need for disability specific coursework within school counselor training, also suggesting further study into the preparation of school counselor to work with specific types of disabilities, rather than all disability categories. Cimsir and Carney (2017) offered the insight that school counselors are not prepared to work with students that have disabilities; further stating that research was needed to determine the cause of this lack of preparedness. Cimsir and Carney (2017) also reported that while training and attitude towards disability did explain some of the variance in perceived counselor preparedness, it did not account for all variation and more research was needed to determine the other factors that help to develop perceived preparedness among school counselors to work with students that have disabilities. Shell (2020) reported that school counselors agree that more training to work with students that have disabilities would help them be more effective; further study to include the type and nature of training that counselors identify as helpful is needed. Shell (2020) also stated that future research evaluating the level of disability focus in training programs was also needed. Thomas et al. (2011) stated that there was a need to examine the basis for perceptions associated with working with clients who have disabilities and the impact of those perceptions on service delivery. Thomas et al. focused on the need for interdisciplinary training and education.

Counselor educators play the primary role in new counselor development. Feather and Carlson (2018) investigated the competency of instructors teaching disability concepts in counselor education programs. Feather and Carlson (2018) recommended a focus on the most effective ways to prepare counselor trainees to work with clients with disabilities. This recommendation for future research is in line with the other disciplines' discussion and recommendations for research into the development of disability competence among counselors.

Summary and Conclusions

While there is a dearth of disability counseling literature, the existing literature does provide direction for the research. The merger of the counselor education and rehabilitation counselor education accrediting bodies also substantiates the need to infuse disability concepts throughout counselor education. Rivas and Hill (2018) called for research into the development of disability competence across a counselor’s career. Much of the literature focuses on counselor trainees and newly trained counselors (Cimsir & Carney, 2017; Rivas & Hill, 2018).

Specifically, the development of disability competence must be explored among established counselors. The next step is exploring the experience of established counselors with little disability exposure working with clients who have I/DD. Evans (2017) called to question the ethics of mental health counselors working out of the scope of their practice when working with clients that have disabilities and highlights the dearth of mental health research and practice for individuals with intellectual disabilities. Evans also used a hermeneutic phenomenological approach that views assumptions and biases to be inherent and unable to be set aside. As new information is gained from the research, those assumptions are revised (Peoples, 2021). Data analysis is cyclic in hermeneutic phenomenology and Evans analyzed their data is this way.

The current study proposes a descriptive phenomenological approach that uses bracketing to set aside bias and view the phenomenon through a clear lens (Giorgi, 2013). Rivas (2017) focused on the development of disability competence among counselors using a broad definition of disability to conceptualize cognitive and physical disabilities. The current study seeks to gain insight into the experience of established counselors by interviewing those that have been licensed for at least five years and working with clients specifically with I/DD. Chapter 3 lays the groundwork for the method of the study, including research questions and protocol, researcher bias, and ethical considerations.

Chapter 3: Research Method

The primary purpose of this study was to gain understanding of experience of mental health counselors when working with clients who have I/DD. Individuals with I/DD make up a significant portion of the population in the U.S., with approximately one in 6 children having a developmental disability and over 7 million people living with intellectual disabilities in the U.S. (CDC, 2015; Schalock et al., 2010). These individuals present unique challenges for counselors who due to gaps in education and research in this area have not received adequate training to conceptualize disability (Boyle et al., 2011). There is a lack of research involving counselors' work with clients who have I/DD, as only about 1% of journal articles focus on disability research (Foley-Nicpon & Lee, 2012; Woo et al., 2016;). Understanding working with this population is the first step in addressing these challenges. This will then allow future research regarding this issue so that counselors working with clients who have I/DD can have appropriate education and supervision necessary to be able to engage in successful counseling. This chapter includes an outline of the research design and rationale, research methodology, and researcher bias, as well as data collection and management strategies.

I sought to address established professional counselors' experiences involving working with clients who have I/DD. I discuss the phenomenological qualitative design, participant recruitment strategies and data collection, and the data analysis plan. My role as the researcher, impact of researcher bias, and ethical implications of qualitative research are also discussed.

Research Design and Rationale

The main question in the current study was, what is the experience of established counselors when working with clients who have intellectual or developmental disabilities? The research questions were:

RQ1: What are the experiences of established counselors when working with clients who have I/DD?

RQ2: How do counselors adapt their counseling practices to work with clients with I/DD?

RQ3: What are influences on disability competence for established mental health counselors?

Based on the goal of the study and research questions, the most appropriate research approach was the phenomenological design. Phenomenological studies are used when little is known about the phenomenon being studied; the goal is to capture detailed descriptions of participants while avoiding researcher bias (Giorgi, 2012).

Descriptions provided by participants were the focus of this research, and it was crucial to capture those descriptions without bias. The phenomenological approach allows rich and detailed descriptions of participants to be captured without researcher bias by using scientific phenomenological reduction (Giorgi & Giorgi, 2003). By exploring and understanding unique experience of each participant, I was able to gain insights regarding experiences established counselors have when working with clients with I/DD.

Researcher Role

In the current study, I was the sole researcher and analyzed the collected data while leaving any out explanation or interpretation. This strategy is in alignment with the descriptive phenomenological method, where description as opposed to interpretation is the goal (Giorgi, 2012). The data are presented in an objective form without the opinion of the researcher or interpretation based upon the literature. In qualitative research, the researcher must be aware of prior experience and bias that may interfere with the research outcome (Giorgi & Giorgi, 2003). Giorgi (2012) refers to this as the "correct researcher attitude"; that is, the researcher must not have any pre-conceived ideas about the research or what is presented and must consider only the research that is presented. The concept of phenomenological reduction becomes even more crucial at this stage of the research, and researcher bias must be addressed so the data can be seen through the pure lens of the participant descriptions without preconceived notions on behalf of the researcher (Giorgi & Giorgi, 2003).

As a phenomenological researcher, it is important that I considered and evaluated my potential biases in regards to the current study. This is supported by Giorgi and Giorgi (2012) as they state the importance of considering researcher bias in phenomenological research. That bias was carefully considered in the current study and care taken in each step of the research process to eliminate potential researcher bias. This was done with reflective journaling, by bracketing my previous experience, and peer review with my

Committee Chairperson. By identifying and being aware of potential biases, the author was able to mitigate their effect on the research as outlined by Patton (2012).

Phenomenological research does not seek to control the phenomenon being studied, but rather seeks to understand and describe the phenomenon. Eliminating researcher bias is crucial to the phenomenological process (Giorgi & Giorgi, 2003). This epoche, or suspension of judgment, is akin to bracketing ones past knowledge and viewing the phenomenon through fresh eyes. This phenomenological reduction occurs when the researcher suspends judgment and focuses on the data provided by the participants; the focus is what is said, not on how the researcher interprets what is said and the goal is to eliminate the bias of the researcher’s past experiences (Giorgi & Giorgi, 2003). This researcher must set aside her views and experiences both professionally and personally and receive data from participants without judgment of that experience. The topic of phenomenological reduction is discussed in some form by all qualitative researchers and its significance and importance is often highlighted (Patton, 2015; Yuksel & Yildirim, 2015; Giorgi, 2012; Giorgi & Giorgi, 2003; Moustakas, 1994). The literature must also be evaluated for conflicting views on the topic of study (Patton, 2012). This was done, and no such views were found. In fact, little research exists on counseling for individuals with intellectual disabilities, despite this population being more vulnerable than the population at large (Mallen, 2011; Nareadi, 2013; Stalker & McArthur, 2012). It is crucial to use the epoche when considering the data to be collected by participants in the current study; therefore, I was mindful of my past experiences and how they influence my outlook and opinions.

Prior to this study, I assumed roles as a student, clinician, and held professional roles working with individuals with intellectual disabilities. As both a master’s and doctoral student in CACREP-accredited programs, I noticed that there was little outside of a brief mention on working with clients that have intellectual disabilities. It became obvious through clinical practice that more was needed in this area, and to see how other clinicians felt about working with this population. I observed certain clinicians working extensively with clients who have intellectual disabilities and wondered where the experience and skill came from. If clinicians made a focused choice to work with clients who had intellectual disabilities, why did they make that choice?

It is worth noting that, although I have had experience and training in working with individuals who have I/DD and other disabilities, my educational background is in clinical mental health counseling. I attended a CACREP-accredited institution for my Master of Science in human services with a specialization in mental health counseling, having graduated in 2007. My degree predates clinical rehabilitation counseling as a specialization within CACREP and the addition of standards for disability coursework. There is an undertone in the literature that shows the discord between clinical mental health and clinical rehabilitation counselors; a rift that will hopefully move the treatment for people with I/DD forward, especially with the 2023 CACREP Standards. Coming from the place of clinical mental health counseling I think it is significant to acknowledge the contributions of rehabilitation and clinical rehabilitation counseling to my work despite not having those specializations. Were it not for the work in those fields to inform my perspective, I would not have the background I do in working with individuals with disabilities.

Additionally, in terms of experience with the selected population, I have worked at a special needs camp for children and adults with disabilities for the past 23 years and have been the camp director for the past 10 years. Working with both children and adults with disabilities in a recreational setting has exposed me to individuals from many different backgrounds. I saw individuals with access to quality services and witnessed firsthand the differences in those individuals as compared to their peers that did not have the same access to services. The disparity did not appear to be financially driver; rather, there appeared to be certain pockets geographically that had more appropriate services than other areas. The experience of working directly with individuals that have cognitive disabilities in a residential setting, albeit short-term residential, has created a passion for advocating for the best possible services to enhance the quality of life for this population.

A new, yet significant bias for the author is having a child with acquired special needs. I had the very unique experience of having had a healthy, typically developing baby who was diagnosed with leukemia at the age of six. Due to treatment complications, he became an at-the-shoulder amputee and sustained a traumatic brain injury. Watching society react to my child gave me a new perspective on the special needs population and what it is like to navigate this world with a disability. I saw a great disparity among what was available for other children as compared to my own child that was now learning to adjust to life without not only a physical disability, but the cognitive impairment that came with the TBI. This made me a passionate advocate for access to the necessary services for my own child to succeed; it also opened my eyes to the need for quality mental health services for my son and the countless others like him.

During the dissertation process, I also became the potential adoptive mother of a baby that was born drug-addicted and came from a tough place before coming to my home at the age of five weeks. She had significant developmental delays that require daily intervention. She was much too young to advocate for herself and I found myself spending more time trying to access appropriate care for her than actually receiving that care. This only furthered my passion for working with the disability community.

While setting aside the experiences of my children and my life was not an easy task, it is a worthwhile task for the purposes of this research. Researcher bias in qualitative research should not be seen as negative, rather it should be seen as the driving force for the passion behind the research (Patton, 2015). The human connection is made in qualitative research, Patton goes on to describe the need for remaining neutral but in a way that expresses empathy and mindfulness. This attitude was maintained toward participants but also turned inward on myself as I conducted the research. Being willing to set bias aside, being present in the moment without distraction, and focusing on gaining insight into the phenomenon being studied is what creates valid qualitative research that can be used to enhance the literature base. An increased literature base can then ultimately enhance the lives of individuals with disabilities.

There may have been occasion for me to know potential participants professionally due to my involvement in the local mental health community. I did not seek participants that were personally known to me, but with snowball sampling that had the potential to occur. Previous professional relationships were acknowledged with participants, and they will be given the option to continue with the study or withdraw. One participant was currently employed at the private practice I worked in ten years prior and one participant attended the same graduate program I did; I had professional relationships with neither participant. I am currently employed as the director of camping and recreation for a non-profit disability services provider, I also see a handful of clients through another non-profit that supports homeless youth. I have not worked for any agency or private practice in ten years and have had limited exposure to other professionals in the field within my community. While I was still peripherally attached, I have not worked with or supervised any other mental health professionals during that time. That time helped to distance me from potential relationships that could cause potential issues with power differential and bias within my research.

Methodology

Population

I sought to understand the experience of established mental health counselors working with adult clients who have intellectual/developmental disabilities. That there were nearly 140,000 mental health counselors in the U.S. in 2017 (Department of Labor Statistics, 2018). Mental health counselors were initially considered any counselor who had graduated from a mental health counseling program and had been licensed as a mental health counselor for a least 5 years at the time of the study.

The criteria for inclusion in the study were graduation from a counselor education program, working as a counselor for a period of no less than 5 years, currently providing individual counseling services, and having worked with at least one adult client with a known intellectual/developmental disability. Counselors having graduated from both CACREP and non-CACREP institutions were considered for inclusion. Initially the IRB parameters for the study were counselors with at least 5 years post licensure as a licensed mental health counselor. However, due to low participant numbers after one month of recruitment, a change of procedure was obtained from IRB to expand the inclusion criteria to counselors with at least 5 years counseling experience regardless of licensure.

Three participants were included in the study who did not meet the initial criteria. P3 worked in community mental health and was currently supervised in clinical practice by a licensed mental health counselor. She was licensed as a social worker which in her state requires 1500 hours of face-to-face psychotherapy experience with clients, which mimics the requirements for licensure as a mental health therapist (Florida Department of Health, 2023). Based on her counseling experience and her clinical position in community mental health she was included in the study. P6 was a registered mental health counselor intern and met all initial inclusion criteria with the exception that she was not yet fully licensed. P8 was licensed as a marriage and family therapist, which falls under the same governing board as mental health counseling. Her master program was within a counseling program having a marriage and family therapy focus.

Sampling

For this study, purposeful sampling was used to ensure participants could provide information about the phenomenon being studied (Patton, 2015). There were a number of community mental health centers, private practice clinicians, as well as colleges and schools located in reasonable proximity to the researcher. Over the course of my professional career, I have built contacts within many of those organizations and the recruitment process began with personal contacts. Snowball sampling was also used in the current study. Snowball sampling allows for one participant to recommend another participant and so on, creating the proverbial snowball effect until the sample size is reached (Patton, 2015). Two participants were obtained as the result of snowball sampling. This was particularly useful in the current study to gain access to the unique participants being sought.

Recruitment

Initially, emails were sent to counseling professionals personally known to the researcher. Settings included private mental health practices, community mental health centers, schools, and colleges. The initial email (see Appendix A) described the study and invited the recipient to participate or share the request for participation with colleagues who may have been interested in participating in the study. The initial email also stated that two additional follow-up emails will also be sent, one after 7 days (see Appendix B) and one after 14 days (see Appendix C). Emails were sent during normal business hours, in the morning, midweek. Each email contained a greeting identifying the researcher, a description of the study, qualifications for potential participants, and a link to contact the researcher. Social media, specifically Facebook and Instagram, were used to recruit participants from this researcher’s local area as there was an established social media presence by the researcher within the mental health community. Posts were be made in mental health advocacy groups on Facebook, as well as the researcher’s personal page (See Appendix D). Posts were made to the researcher’s personal page on Instagram, tagging mental health advocacy groups. Posts were made in the morning and after business hours to likely reach the most potential participants. A total of six posts were made over the course of a two month period; two posts approximately every ten days, one week day and one weekend day. The weekday post were made mid-week in the evening, and the weekend posts were made mid-morning on Saturday. Posts made on the weekends received the most interaction. Potential participants were also asked to refer other potential participants, regardless of eventual inclusion in the study. Fourteen potential participants were identified, six did not meet inclusion criteria, two were initially included but it became known later that they did not actually meet inclusion criteria, and six participants were included in the study. Information regarding clients was assumed true; participants were not asked to provide documentation on clients to demonstrate disability. Participants' licensure was be verified through the Department of Health's public licensure lookup portal.

Participant Selection

Potential participants who completed the online information survey were contacted by phone for a brief screening interview. Purposeful sampling was used to select potential participants following the screening interview. Purposeful sampling, a hallmark of qualitative research, allows the researcher to identify participants who may best be able to inform the study (Cleary, et al., 2014). The goal of purposeful sampling is threefold; participants that are indeed familiar with the phenomenon being studied, willing to share their experiences and opinions surrounding the phenomenon and have the skills necessary to effectively communicate their views (Engelander, 2012). Potential participants were informed that a phone interview does not mean automatic inclusion for the study and potential reasons for non-inclusion; potential participants were be informed of the need to have a representative sample across length of time in practice and the number of clients with intellectual disabilities. Participants who were able to provide detailed descriptions with minimal prompting, were engaged with the interview process, and met the criteria for the study were invited to participate. All potential participants were afforded the opportunity to have access to the results of the study, regardless of inclusion in the study. Once a participant was accepted into the study, they were asked to complete an informed consent document. The informed consent was sent electronically via email and the participant replied with the words "I consent."

Sample Size

For the purpose of the current study, six participants were used until saturation of data was reached. The goal of qualitative research is to have a thick, rich description of the phenomenon being studied; data saturation is key for that to occur (Patton, 2015). Deciding the number of participants needed to reach saturation is a complex issue; each study will have different needs that will affect when saturation is reached (Bernard, 2012). An appropriate phenomenological sample size is one that addresses the research questions with saturation of the data and there is enough information to replicate the study (O'Reilly & Parker, 2012). O'Reily and Parker (2012) explained that data saturation occurs when there is no new data and therefore there are no new themes. The number of suggested participants for a phenomenological study varies greatly by author, with Creswell (1998) suggesting 5-25 participants and Morse (1994) suggesting at least six. The goal of data collection is to reach saturation where no new themes are emerging and a sufficient amount of data has indeed been collected (Creswell, 2013).

Participant Screening and Selection

To remain transparent, the current study outlined the data collection procedures in depth. Transparency is crucial in phenomenological research, especially during data collection and sufficient detail must be included about how the data were collected (O'Reilly & Parker, 2012). Data was collected via telephone (short pre-interview to schedule interview time and determine the appropriateness of the potential participant to provide rich and detailed descriptions necessary for the study), and video interviews via

Microsoft Teams due to social distancing requirements due to the coronavirus pandemic. After the screening call, participants were emailed a confirmation with their interview date and time, as well as the informed consent document.

The screening data collected asked for the year of graduation from a master's degree program, type of program, licensure type, date of licensure, length of clinical practice. Once screening data was collected, potential participants were selected for the phone interview process. The goal of the phone screening was to assess the suitability of the potential participant to provide the necessary detail in the formal interview process.

Screening calls (see Appendix E) were brief, lasting between three and five minutes to assess the potential participants' suitability for the study by asking questions related to current clinical practice and if they had experience outside the clinical setting with individuals that have disabilities. The interview were also be scheduled during the screening call.

Data Collection and Analysis

Data Collection

The purpose of the video interviews was to gain insight into the experiences of the counselors' work with clients that have intellectual/developmental disabilities. While 60 minutes was scheduled, the goal time of each interview was 50 minutes. Prior to the start of the interview, participants were asked rapport building questions regarding their clinical practice history and any history working in the disability community outside of clinical practice. Participants were asked what it like to work with a client that has an intellectual disability, how that has changed across the time of their clinical practice, and what their first experience was like and what that experience is like currently (See Appendix G for a full list of interview questions). The quality of qualitative data is measured by the depth of the data (O’Reilly & Parker, 2012), so effective interviewing strategies will be implemented. Interview procedures included open-ended questions, the use of silence in the interview to invite the participants to say more without prompting, consistent prompts for more detail when needed across interviews, neutral tone and body language on behalf of the researcher (Laureate Education, 2010).

Data Management

The management of data is crucial to research as participants must have their confidentiality respected and all data must be properly and securely stored; this is especially true in qualitative research where data are often transcripts, notes, and other handwritten materials. Data in the current study included recorded interviews, written transcriptions stored electronically and in print, and handwritten notes. All handwritten data was kept in a locked file at all times unless under the direct control of the researcher for review or coding purposes. Handwritten data included the researcher’s field notebook as well as marked up copies of interview transcriptions.

Data was recorded with the computer software program, Microsoft Teams. Recorded data was password protected and destroyed after the time set forth by the Walden University Institutional Review Board. The data was not shared arbitrarily with others during the research process; data was only shared with Walden University faculty for the sole purpose of dissertation review. While the nature of the current study did not ask participants to reveal particularly sensitive information, pseudonyms will be used to identify participants. This practice is well established in the literature and is used in conjunction with other practices such as non-disclosure to protect study participants. Participants were identified by their name only in the screening process and on the informed consent document. Each participant was immediately assigned a number based on the order of interview (P1, P2).

All data were kept confidential, and results reported anonymously. Morse and Coulehan (2015) stated that participant confidentiality is crucial to academic research so as little demographic or identifying data as possible should be disclosed. Identifying data were removed from the interview transcriptions; names were replaced with an alias and potentially identifying demographic data was replaced with generalities so that it was not possible to determine employment, location, or other demographic information. The demographic information reported in the current study included age, gender, degree type, years of clinical experience, and whether or not the participant had relevant outside experience with disability either personally or professionally.

Data Analysis Plan

Qualitative data can be analyzed by hand or with the assistance of computer-generated software (Patton, 2015). Data in the current study was hand coded to allow for the richest descriptions and themes of the data to emerge. Interviews was initially transcribed through the platform recording the interviews and then verified by the researcher for accuracy. Transcripts were also reviewed by the committee chair to verify accuracy. The researcher had limited information about the phenomenon being studied and there is little in the research to inform the researcher.

The coding process developed as interviews inform the research process; later interviews verified information gathered in earlier interviews (Morse, 1997), a form of triangulation within the research. Hand-coding data allows the researcher to learn from each interview and attribute meaning to small details that cannot exist without direct contact with the data. Qualitative research calls for a relationship between the researcher and the presented data (Morse, 2015); the data must be read and re-read a multitude of times for the researcher to be able to find themes and meaning within the data. Hand coding data requires the researcher to read and re-read the data multiple times as they look for themes and ideas within the data.

Phenomenological psychology research is a holistic approach to data collection that looks at the whole picture of what is being studied (Giorgi, 2012). Giorgi (1987, 2012) describes five unique steps by which phenomenological data is analyzed: the researcher firsts reads all of the data completely to begin to understand the whole of what is being studied; the researcher then goes back and rereads all the data and begins to look for what stands out, these points are referred as meaning units and will often vary between researchers; next the researcher begins to translate the words of the participants into concepts that are central to the phenomenon being studied; the concepts are then taken and the essence of the experience can be described and structured; finally, in the last step, the now structured data can be analyzed and interpreted.

The phenomenological method of research calls for the researcher to first begin with the correct attitude; one of phenomenological reduction where the researcher takes what is presented without opinion and removes any previous knowledge about the phenomenon being studied (Giorgi, 2012). I adopted the attitude of phenomenological reduction in the current study by allowing the data to tell each participants' story without bias. Interviews were transcribed verbatim. Any identifying demographic data or other details that could potentially identify a participant were removed from the transcript. Transcripts were reviewed and compared to the recordings to ensure accuracy. Transcripts were then read in their entirety without any note-taking or other interruptions; the goal of this was to begin to a view of the larger picture and understand the whole. Transcripts were then re-read, one by one and as themes shift in meaning the transcripts were marked accordingly. This is the second step of the phenomenological method as described by Giorgi (2012). For each reading of the transcripts, a different color will be used to mark the transitions noted.

The next step is when data are put into more formal terms while still remaining true to participants' words (Giorgi, 2012). During this step, I identified and named concepts and ideas that the participants state in a uniform way throughout each interview so that themes can be identified. These meaning units were also confirmed by my committee chair. Themes were also coded by color for easy identification. Each interview was handled individually for each reading of the transcript and the transcript was read in its entirety before moving on to another transcript.

Each transcript was also read and reviewed with free imaginative variation; that is allowing any potential perspective to emerge without bias. Through the process themes were expanded and collapsed as the experiences of the participants were analyzed. This was done so that data were then able to be reported in a concrete and concise manner without bias. My field journal served as a place to record thoughts and ideas from interviews, as well as act as a space to express ideas and perceptions prior to reading transcripts in order to remove bias. The end result of the data analysis were themes and insights into the lived experience of the participants based on the thick and rich descriptions provided in their interviews.

Trustworthiness

Analyzing qualitative data presents many challenges, including the trustworthiness of the data. Lincoln and Guba (1985) first used the term trustworthiness to describe the type of academic rigor required in qualitative inquiry; that process has remained largely the same since its inception in the 1980s.

Trustworthiness must be established in qualitative studies in order to demonstrate to the scientific community that the research is not simply anecdotes from participants put together to form an opinion (Williams & Morrow, 2009). To establish trustworthiness, there must be a clear rationale for the study, the data collection method and data analysis plan must be well described, and the data must be clearly interpreted.

The four main components of trustworthiness are credibility, transferability, dependability, and confirmability, each having its own unique role in establishing trustworthy research (Guba, 1981). Data were carefully and fully analyzed to create transferability of the data, which is the goal of qualitative research, unlike the goal of generalizability in quantitative research (Patton, 2015).

Credibility

Credibility is the concept that data is true or has truth value (Guba, 1981). According to Guba (1981), credibility is best confirmed with member checking, where the participants themselves provide feedback as to the credibility of the stated data. However, Giorgi (2006) did not endorse member checks; he believed participant confirmation of data analysis takes away from the phenomenological approach of phenomenological reduction where the researcher approaches the data without bias. Giorgi argued his position differentiates between lived experience and the analysis of that experience.

In an effort to mitigate these two perspectives, and fully acknowledge my position as a new researcher within my doctoral program, I used member-checking despite the fact that it does go against Giorgi’s descriptive phenomenological method. Follow-up interviews were used as needed to clarify any information from the initial interview, which will allow the participant to provide more detail as necessary. P1, P2, and P8 had follow-up interviews. Participant interviews continued until data saturation was reached. Data saturation is the point at which no new data is expected to be found and themes among participants are overlapping (Guba, 1981). After the six initial interviews there appeared to be data saturation; after the three follow-up interviews with no new emerging themes data saturation was confirmed.

Transferability

Transferability is the applicability of the research; it begs the question, “how can this apply to other situations or other populations?” (Guba, 1981). Giorgi (2006) conceptualized transferability as the idea that a study could be replicated but not judged, meaning that a phenomenological study could be replicated to gain new insights into the phenomenon but not to prove or disprove the original inquiry. As such, the current study sought to provide complete and thorough data analysis as called for by Giorgi (2006) for effective replication of a study. Participant descriptions were presented in a way that captures the detail of their lived experienced; this tick, rich description was key to putting participant descriptions into the necessary context (Peoples, 2021).

Dependability

Dependability is the consistency within the data or how likely the data is to be repeated with different participants or across future studies (Guba, 1981). In the current study, this concept was addressed with data saturation. Themes within the transcripts were analyzed and the number of participants interviewed was reached when the same themes begin to duplicate. This is supported by Giorgi’s (2006) handling of redundancies within the data; while once discarded from a philosophical standpoint, they have great meaning within the research to enhance dependability. The data were also submitted to my dissertation committee chairperson for review in order to audit the research procedures including data collection and analysis.

Confirmability

Confirmability is a neutral and objective portion of trustworthiness. It is the manner in which the researcher bias is mitigated within the study (Guba, 1981). This concept is key to Giorgi's (2006) phenomenological method; the premise is that of phenomenological reduction whereby the researcher removes her own meaning from the data and allows the data to speak for itself. I spent time and took great care to suspend my own beliefs when analyzing the data, including taking steps to ensure that the data will be read for its own value. These steps helped create an audit trail that allowed a clear and transparent description of the research process (Lincoln & Guba, 1985).

Transcripts were read one at a time so that the unique perspective of the participant was gained, time was taken prior to reading of each transcript to focus on the data and nothing else, transcripts were read and analyzed in the same physical space, and interruptions were minimized during the reading of transcripts. Notes were kept on each interview. The notes were kept in a notebook, handwritten, and organized by each interview with identifiable data removed. The notes were discussed in weekly meetings help during the data collection and analysis process with the committee chairperson. Each interview occupied its own section of the notebook with notes, observations, and rationalization for the entire process as it related to that particular interview.

Data triangulation is a primary means to ensure data saturation. Data triangulation is gathering information from multiple sources. The current study used data triangulation in several different ways, using participants that have varying levels, years, and types of experiences, and multiple methods of collecting data from each participant including screening questions, screening interviews, and interviews.

Ethical Considerations

I followed the American Counseling Association’s Code of Ethics (2014) guidelines for conducting ethical research. The Code of Ethics calls for research to protect participants; research must be conducted within the standard of practice, researchers must take necessary precautions to avoid harm to participants, and participant confidentiality must be maintained. The current research had provisions to protect participants’ confidentiality as well as their well-being by collecting and storing data in a secure and confidential manner; well-being was protected by non-invasive nature of the research as well as by making resources available to all participants. Interviews were non-judgmental and conducted in a neutral manner. Informed consent was obtained via email for each participant.

The ACA places these responsibilities on the lead researcher in a study; this study had only one researcher and that responsibility therefore fell to me. The academic process of completing my doctoral and master’s degrees, as well as maintaining licensure as a mental health counselor have provided me with a good ethical foundation. Moreover, my own ethical boundaries and moral compass allowed me to conduct and complete ethical research. The dissertation process also has multiple rounds of checks and balances throughout the process to ensure that research is ethical, including committee reviews of work at the prospectus and proposal stages prior to the collection of any data, the IRB process, as well as maintaining frequent contact with my committee chair throughout each term I am enrolled in the dissertation course shell.

Walden University’s IRB also has strict standards that must be followed, including obtaining informed consent from each participant, detailing the potential risks and benefits of the study, and the voluntary nature of the study (Walden University, 2016). Privacy and confidentiality were also considered. Confidentiality is critical when conducting research; confidentiality goes beyond anonymity. All information provided by participants was kept confidential; paper documentation were stored in a locked file, while electronic data was password protected.

While it is unlikely that the current study would have caused emotional or other harm, participants were informed of this risk and provided with contact information should additional support be required. While the research questions were not of a highly sensitive nature, discussing any therapeutic process in great detail can be potentially distressing (Gobson et al., 2012). A plan for participants that showed any distress was established, however this did not occur during the interview process with any participant. All participants were provided information on disability competence and had the opportunity to have a copy of the results of the study.

All participants were offered the opportunity to read the completed study once was accepted by Walden University and submitted for publication per the requirements of the researcher's doctoral degree. Participants were also sent a summary of the results of the study (see Appendix G). Additionally, potential participants that were not selected for participation in the study also had the opportunity to request the study results. Participants were also offered information about working with clients that have intellectual disabilities that was based upon the current literature (see Appendix H).

Summary

I sought to gain insights and understand experiences of counselors working with clients who have I/DD. There is little current literature that discusses this phenomenon, making the phenomenological approach the best option to address the problem. Chapter 4 includes a discussion of data collection and analysis procedures, as well as evidence of trustworthiness and results of the study.

Chapter 4: Results

The purpose of this study was to understand experiences of established counselors working with adult clients who have I/DD. I explored descriptions of mental health counselors with at least 5 years of experience counseling clients with I/DD. This chapter includes a discussion of the research setting, participant demographics, data collection and analysis, evidence of trustworthiness, and study results. The manner in which biases were monitored and addressed is also discussed.

Research Setting

The setting for the current study was my home office. All participants participated from their home or professional office. Interviews were conducted via Microsoft Teams. I was alone in my home office during interviews, and all participants indicated they were also alone during interviews. The nature of online interviews allowed me to interview participants from a range of geographical areas, and not just the area in which I was located. There were no interruptions or technological issues during interviews; all interviews were completed without issue.

Participant Demographics

A total of eight primary participant interviews were conducted. The participants were three males and five females ranging in age from 32 to 61. Five counselors were licensed in their field, and one was a registered intern. There were four licensed mental health counselors, one licensed clinical social worker, one licensed marriage and family therapist, and one registered mental health counselor intern. Two therapists did not meet these criteria, despite answering the screening questions affirmatively. P4 had a master's degree in sociology and was working out of field. P5 had only 2 years of clinical experience despite having years of experience working with clients in forensic settings. All six participants had previous experience working with individuals with disabilities outside of the clinical mental health setting. Experiences of participants ranged from 7 to 36 years (see Table 1).

Table 1

Participant Demographic Data

Participant	Age	Gender	Years' Experience	Degree Type	Licensed	Professional Experience	Personal Experience
P1	48	Male	12	Counseling Psychology	Yes	Yes	Yes
P2	45	Male	17	Mental Health Counseling	Yes	Yes	No
P3	61	Female	36	Social Work	Yes	Yes	Yes
P6	44	Female	11	Counseling and Psychology	No	Yes	Yes
P7	32	Female	11	Counselor Education	Yes	Yes	Yes
P8	32	Female	7	Marriage and Family Therapy	Yes	Yes	No

Participant 1

P1 was a 48-year-old male with 12 years of experience. He was a licensed mental health counselor with a counseling psychology master's degree he received in 2011. He had a professional background as a caseworker for clients with intellectual disabilities. His older sister had Down syndrome.

Participant 2

P2 was a 45-year-old male with 17 years of experience. He was a licensed mental health counselor with a mental health counseling master's degree he received in 2006. He also has a PhD in counselor education and supervision. He has a professional background in community mental health. He is also a professor in counselor education programs.

Participant 3

P3 was a 61-year-old female with 36 years of experience. She was a licensed clinical social worker with a master's degree in clinical social work she received in 2012. She currently worked as a clinical counselor in a community mental health program. She had a professional background involving working with clients with intellectual disabilities as a case manager. She volunteered with the Special Olympics.

Participants 4 and 5

P4 and P5 were not included in the study because they had less than 5 years of counseling experience. P4 was a 28-year-old-male with 2.5 years of experience and a master's degree in clinical social work. He was a clinical social work registered intern. P5 was a 28-year-old year female with 2 years of experience and a master's degree in sociology. She did not have a mental health license.

Participant 6

P6 was a 44-year-old female with 11 years of experience. She was a registered mental health counselor intern with a counseling and psychology master's degree she received in 2008 and post-master's degree in clinical counseling she received in 2020. She had a professional background working in a special needs school for behavioral health. She had a child with ADHD.

Participant 7

P7 was a 32-year-old female with 11 years of experience. She was a licensed mental health counselor with a master's degree in counselor education with a specialization in general mental health she received in 2016. She had a professional background in working with individuals with disabilities through vocational rehabilitation. She had a daughter with type 1 diabetes.

Participant 8

P8 was a 32-year-old female with 7 years of experience. She was a licensed marriage and family therapist with a master's degree in marriage and family therapy she received in 2015. She had a professional background working in a community program for people with intellectual disabilities.

Data Collection and Management

The data collection process began on August 26, 2022 and ended February 9, 2023. A total of eight primary interviews and three follow-up interviews were conducted. Participants were recruited through email and social media, specifically Facebook and

Instagram. IRB-approved email and social media posts contained selection criteria and well as my contact information. Emails and posts encouraged sharing with other participants and snowball sampling led to three additional participants for the study. When interested potential participants contacted me via email, I scheduled a brief screening call taking approximately 5 minutes. Eligible participants were then asked for demographic data followed by recorded interviews via Microsoft Teams. Informed consent was obtained from each participant in writing prior to their first interview. Participant solicitation did not yield necessary participants, and additional emails and social media posts were created. A revision to inclusion criteria was also necessary, and IRB approval for this change was obtained. The original inclusion criteria of at least five years of experience post licensure as a licensed mental health counselor was revised to at least five years of counseling experience regardless of licensure.

All data were collected using telephone, email, and Microsoft Teams. A total of eight participants completed the study, resulting in six valid interviews. Five participants were mental health counselors with at least five years of experience and had worked with at least one adult client with I/DD. One participant was a clinical social worker working as a counselor in a community mental health adult outpatient center. Each interview (including interviews that were not analyzed and three follow-up interviews) lasted between 13 and 52 minutes and were recorded on a password-protected personal laptop with a secure and password-protected private internet connection. Each interview was conducted on separate days, and transcripts were read for the first time before conducting further interviews. All email correspondence occurred via my password-protected Walden University email account. Telephone calls were made via my personal cell phone while in my home office where privacy could be ensured. Interviews were transcribed automatically via Teams and then watched and corrected as necessary by. Notes on each interview were maintained in a field journal that was kept in a locked drawer in my home office.

Data Analysis

The phenomenological approach allows the detailed descriptions of the participants to be captured without the burden of researcher bias by using scientific phenomenological reduction (Giorgi & Giorgi, 2003). Researcher bias in qualitative research should not be seen as negative, rather it should be seen as the driving force for the passion behind the research (Patton, 2015). Being intentionally mindful of this, data were analyzed using Giorgi's method of descriptive phenomenology. As described in the methodology, Giorgi (1987, 2012) describes five unique steps by which phenomenological data is analyzed: The researcher firsts reads all of the data completely to begin to understand the whole of what is being studied; The researcher then goes back and rereads all the data and begins to look for what stands out, these points are referred as meaning units and will often vary between researchers; next the researcher begins to translate the words of the participants into concepts that are central to the phenomenon being studied; the concepts are then taken and the essence of the experience can be described and structured; finally, in the last step, the now structured data can be analyzed and interpreted. This process was followed for each participant interview.

Additionally, phenomenological reduction, or the suspension of previously held beliefs, is core to the phenomenological method (Giorgi, 2012). The researcher took time prior to each interview and during data analysis to be purposely aware and mindful to let participants speak for themselves and to analyze the data with a neutral, curious mindset.

Each participant was assigned a pseudonym immediately following their interview corresponding to their order in the interview process (e.g. P1, P2). Participant interview transcripts were read first for accuracy, correction, and to delineate between researcher and participant responses (see Appendix I). Transcripts were then read a second time to get an understanding of the entire participant interview, completing Giorgi's first step (Giorgi, 2012). A third reading was then conducted, and individual meaning units were highlighted in the transcript. Giorgi's (2012) second step involves reading participant transcripts again and identifying meaning units. Meaning units were highlighted in the transcripts and then put into tables for each participant (see Appendix J). In the third step of the Giorgi (2012) method meaning units are changed into psychological terms while still remaining true to the meaning assigned by the participant; in this step emerging themes begin to be identified. In the current study, meaning units were then translated into psychological statements in the same table with the meaning units. The fourth step of Giorgi's (2012) method is describing the essence of the experience of the participant and identifying themes for each participant. This step served as the coding process for study; all qualitative data must be coded for themes within the data (Patton, 2015). In the current study data was coded by recording themes in a column alongside the meaning units and psychological statements for each participant. Themes were reviewed and clarified in consultation with an outside source (committee chairperson). The final step of Giorgi's (2012) method is to use the identified themes from each participant to describe the overall phenomenon. In the current study themes were reviewed and condensed into five main themes; competence, joining, comparing, regard, and encouraging. Each theme is discussed in detail later in this chapter. Discrepant data is also discussed. The chapter concludes with deep descriptions of each participant's experience and a synthesized description of the phenomenon.

Evidence of Trustworthiness

Trustworthiness is the academic rigor assigned to qualitative data and is composed of credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Trustworthiness is crucial part of a qualitative study and the current study included protocol to enhance the trustworthiness of the study. For general trustworthiness, participant statements were kept verbatim, including extraneous language such as "like" or "um". Additionally, themes were created for each participant independently and then later combined and revised to keep the integrity of each interview. The development of themes included seeking input and feedback from someone familiar with coding and thematic development; the committee chairperson was involved throughout the data analysis process, including assigning meaning units, coding data, and developing themes.

Credibility

Credibility is the idea that the data collected is true (Guba, 1981). According to Guba (1981), credibility is best confirmed with member checking, where the participants themselves provide feedback as to the credibility of the stated data. However, Giorgi (2006) does not endorse member checks, but his method does support follow-up interviews. The current study had 3 follow-up interviews where information was restated from the first interview to enhance credibility and also clarify participant meaning. Participants 1 (see Appendix L), 2, and 8 had follow-up interviews. Data saturation is another method of enhancing credibility (Guba, 1981) and participant interviews were conducted until overlapping themes were found and no new themes emerged.

Transferability

Transferability is the applicability of the research to other populations (Guba, 1981). Giorgi (2006) described transferability as the ability to accurately replicate a study to gain new insight into the phenomenon. Peoples (2021) cited the importance of capturing the detail of lived experience in qualitative research. In the current study I specifically asked opened ended questions and followed up participant responses with more questions to get a full, rich description of their lived experience. For this reason, follow-up interviews were also used with 3 participants. Additionally, the current study was expected to be limited by geographical constraints, however, is less limited than expected due to the on-line format of interviews, solicitation via social media, and snowball sampling. The study also included mental health counselors, a social worker, and a marriage and family therapist, offering a variety of perspectives on the counseling process. However, transferability in qualitative data can be very limited (Guba, 1981). The current study and its results can help to inform the counseling community about the experience of certain, established counselors working with clients who have I/DD.

Dependability

Dependability is the consistency within the data (Guba, 1981). In the current study this was addressed with data saturation and the rigor of the interviews. Giorgi (2006) referred to saturation within the data as redundancies within the data and in philosophy they were initially discarded, however these redundancies in qualitative research are what create dependability in the research. Data saturation was reached with the participants and themes began repeating within the interviews; this is especially clear in the themes of competence and joining, with all the participants making multiple statements in their interviews regarding each of the themes. The research questions were asked in the same order and necessary follow-up questions were structured in a similar manner across participants. The research process was closely supervised by my committee chairperson and had Institutional Review Board approval (Approval number 08-05-22-028126) as having met the criteria for ethical research.

Confirmability

Confirmability is a neutral and objective portion of trustworthiness; it is the part of trustworthiness that addresses researcher bias. (Guba, 1981). This concept is key to Giorgi's (2006) phenomenological method; phenomenological reduction occurs when the researcher removes her own meaning from the data. Prior to each participant interview I took time to read through the interview questions and allow myself to get into the mindset of being a. neutral researcher, open to hearing the words of the participant and taking it at face value without judgment or passing it through the lens of my experience. To further enhance confirmability, meaning units were highlighted in the transcript, my chairperson read the transcript with meaning units and provided feedback. This occurred with the first 4 interviews while the researcher became familiar with the research protocol and the phenomenological method. Meaning units, psychological statements, and themes for all interviews were provided to my chairperson, feedback was received and discussed to finalize all meaning units. I kept a field journal to track thoughts and ideas from each interview. Those notes were kept in real time and used in the discussion of the data and in Chapter 5, in the discussion of future research.

Researcher Bias

In qualitative research the researcher must be aware of the potential for bias and must take steps to remain objective throughout the data collection and analysis process (Giorgi & Giorgi, 2003). Free imaginative variation is the consideration of different perspectives without judgment of the perspective as being right or wrong (Giorgi, 2012).

Participants had widely varying perspectives and those perspectives were considered from the bracketed perspective of the researcher. Bracketing, or the suspension of judgment (Giorgi, 2012) was used to make sure my perspective was not placed onto the participants' experience.

Throughout thematic development the researcher was mindful of taking a step back before reviewing the data to ensure the correct researcher attitude and to step into the epoche, or suspension of judgement, of the data (Giorgi, 2012). The researcher also relied on the objective perspective of the committee chair throughout data analysis. I used my field journal to document ideas and perceptions as they occurred so that they did not interfere with my ability to remain an objective researcher.

Results Section

The goal of the study was to gain insight into the experience of mental health counselors working with clients who have I/DD. The results of the current study yielded five unique themes across participants: competence, joining, comparing, regard, and encouraging. Competence, joining, and comparing were themes across all participants, with competence being the most frequent theme. Regard and encouraging were themes in five participant interviews. The first interview question asked clients to describe their experience working with clients who have I/DD. See Figure 1 for a visual diagram of the results across participants.

Table 2

Themes Across Participants

Theme	**P1**	**P2**	**P3**	**P6**	**P7**	**P8**
Competence *Previous Experience*	x	x	x	x	x	x
Joining *Understanding* *Bridging*	x	x	x	x	x	x
Comparing	x	x	x	x	x	x
Regard *Paternalistic Altruism* *Us versus Them Thinking*	x		x	x	x	x
Encouraging	x	x	x		x	x

Theme of Competence

Competence was defined as participants' perceptions of their own abilities to provide adequate counseling services to clients with I/DD. The theme of competence was addressed within the meaning units of all participants. Competence was dimensional, with participant reports varying from low to high competence. Competence included participants' assessments of previous training/education experiences. Competence included the initial themes of lacking, assessing, and perceived expertise; these themes were incorporated into competence during the coding and thematic development process. The conceptualization of competence also included being able to assess where/how a client functions from a developmental perspective. Prior experience was initially an independent theme; however, it was determined that the concept of prior experience was not a theme but rather a description of where competence was developed. The sub-theme of prior experience included where the competence came from (e.g., prior professional experience, personal experience) and attempts to gain more knowledge surrounding working with I/DD clients through continuing education, supervision, and/or experiential opportunities.

Much of the theme of competence was surrounding a lack of skills and confidence. P2 described working with a client who had I/DD by saying, “And that's kind of like what's going on in my head a lot of the time is just. Feeling overwhelmed, I don't know where to go.” He described feeling like the best that he could do was not to make the situation worse and try to provide some supportive services, describing it more like case management as opposed to therapy. P8 described her thought process when working with an I/DD client:

> What's going through my head? My thought, like my personal thoughts are kind of like, “Crap, like I'm not equipped for this, like I don't know what to do.” And then I kind of find myself going to what I know, which is minimal.

Conversely, P1 described his competence in working with clients who have I/DD and being able to translate that knowledge into helping others understand disability as well. P1 explained it as he’s “shown multiple parents how to do this. You know somebody on the spectrum, who doesn't speak a lot if you can connect with them, they won't shut up once you make that connection.”

The theme of competence also includes participants’ perception of working with I/DD clients as requiring a different skill set than working with clients without disability. P1 said, “and then it's, it's just having the patience to do it” when explaining the differences when working with clients who have I/DD as opposed to clients without disability. P7 described working with I/DD clients by saying, “it requires a different skill set of being able to simplify some of the concepts that we work on here.”

Previous Experience

A significant sub-theme of competence is previous experience, Participant’s past personal or professional experiences with, and training or education about, persons with I/DD. All participants described previous professional experience with disability and 5 participants had personal experience with disability. P3 explained “before I got my master's degree, I worked for many years, most of my professional career has been working with people with developmental disabilities, doing case management.” P7 reported, “so for me, I worked for several years… with adults and teens with disabilities in more of a vocational rehab type environment.”

Participants spoke about how their experience shaped their clinical competence. P3 explained:

> because I already had the background working with people with intellectual disabilities, it wasn't that much harder for me. I just talked to them, just like I did as a case manager, except for more focusing on anger issues, anxiety issues, depression, those types of things.

Included in the sub-theme of previous experience are participants’ descriptions of the training they received in their master’s programs. the lack of training within participants’ graduate programs to work with clients that had I/DD. P2 stated, “but my program? No, we barely…the program I was in…we didn't even have a formal DSM [Diagnostic and Statistical Manual] diagnosing class.” In response to educational experience, P6 replied,” No. No, like the only time I think we ever talked about working with people with disabilities is when we were going and talking about behavioral, behavioral analysis or behavioral counseling. P8 explained, “mostly working at [disability services] is where I got most of my training.”

Theme of Joining

Joining was conceptualized as the way participants described establishing a therapeutic rapport and the effort to connect to the client. Joining included the initial themes of connecting, bridging, navigating, engaging, understanding, translating, and approaching which were all synonymous with joining as coding and thematic development progressed. Descriptive phenomenology requires the reading and rereading of participant manuscripts (Giorgi, 2012) and thematic development was clarified and enhanced through these readings. Understanding and bridging were significant enough to be considered sub-themes of Joining. Understanding is the way participants helped their clients or others navigate and conceptualize disability. The sub-theme of bridging was developed as participants described the need to access clients with I/DD differently than clients without disability; P1 conceptualized this as “building a bridge”.

Joining was described by participants as establishing appropriate rapport and make the session developmentally appropriate were addressed frequently by participants. In session with an I/DD client P1 described his initial approach as, “Finding a way to, I have to find a way to connect with the individual”. P3 characterized I/DD clients’ understanding of the therapeutic process, “They do get it, but they have to get it in their way.” P8 talked about the need to make sure skills and concepts were presented in a way that clients can understand, saying she “kind of focus[es] more on that and really pay[s] attention to, like, how can they actually learn some of these skills.”

Understanding

Understanding was a sub-theme of joining, where participants described helping clients or others to understand their disability and disability concepts in an effort to develop and foster rapport as well. P1 described helping a client understand the way his brain worked so the client could learn to interpret the actions of others.

> So it's teaching about his brain and (telling him) “People don't make decisions based completely on rationality. That it's your emotional side of your brain that makes decisions”, and this light bulb went off in his head like, what?… [The client then said,] “It's like that makes things so much easier. I never even considered it that way.

P3 discussed a client who was frequently in trouble at home because his mother was interpreting aspects of his disability as a refusal to follow directions and she was able to work with the mother to help her understand her son’s disability.

> And one of the things I'll say about this particular case is I ended up towards the end bringing mom in. And saying to her, you do realize I said, “I'm not trying to tell you about your son, you're his mom, I get that, but from a clinical point of

> view he does not think outside the box. He will not show initiative. This is part of his disability.” So I did some, some psychoeducation with the mom.

Bridging

A reoccurring motif within joining was the idea that I/DD clients somehow had to be accessed differently than developmentally normal clients. Most participants used imagery of secret codes, bridges, or keys in describing how they approached I/DD clients and described this process as necessary for effective counseling. The idea of needing to connect to clients with I/DD in a way that was different from the way a participant would a client without a disability was discussed in some capacity by each participant. P1 described it as being his “job [is] to build a bridge into their world, because if I do, then they're more likely to build a bridge back to me.” P2 said they had to “ask more closed ended questions than I normally would… if I asked open-ended questions, I usually would have to stop myself and clarify” in order for clients with I/DD to engage in the therapeutic process. P7 said that she “realized that they have that extra barrier that they're up against that I want to make sure that I'm accommodating them for that.

Theme of Comparing

Comparing described conceptualizing different forms of I/DD, specifically, ASD, differently than other intellectual and developmental disabilities as though somehow autism is not as severe. Comparing also encompassed an initial theme of discriminating but through thematic development, it became clear the statements were not coming from a place of judgement or bias, but rather as delineations of differences between the I/DD and non-disabled populations. All participants have meaning units coded to comparing.

Comparing occurred when participants described one disability as being different from another, as though clients were somehow less than or better than others because of the nature of their disability. P1 described clients with I/DD that sought counseling, saying, “Yeah, it's been people in the autism spectrum- people with like regular developmental disabilities don't come in for therapy.” P3 also specifically differentiated between autism and other developmental disabilities, conceptualizing a client by saying, “She's more I would say developmentally disabled, [not autistic] but, at the higher end also”. P7 was talking about her own child as compared to other people with what she conceptualized as more significant disabilities and said, “She just has diabetes; you know what I mean?”

Comparing also occurred when participants described clients and their assumptions about I/DD clients’ ability to understand and process. P6 said:

> Do they really understand what I'm saying? Do they understand the idea that I'm trying to get across to them? How much are they really processing? And are they able to utilize this outside of the session?

Describing the approach to working with I/DD clients, P8 said, “I find myself like kind of talking slower, not using bigger words that I might use with like a more high functioning client…feeling like I don't use a lot of those bigger clinical words I might use.” She explained that she didn’t want to make the client uncomfortable by using terms they would not understand. This is not something she was concerned about when working with clients who do not have an I/DD.

Theme of Regard

Regard was coded as a theme that initially included meaning, justifying, and conceptualizing. The overarching meaning of regard is the way participants think about their clients with I/DD, positively and negatively. Six participants had meaning units coded as regard. Regard includes participants' feelings toward clients with I/DD, the meaning counselors ascribe to working with I/DD clients, and the mindset of participants when engaging with clients who have I/DD. Paternalistic altruism is a sub-theme of regard and was found in participant meaning units when the regard was stemming from an altruistic perspective. Us versus them thinking is also a sub-theme of regard and describes participants' perceptions of their clients as different from their clients without an I/DD and as needed special attention other clients did not. Participants described being in session with clients with I/DD and recognizing that the therapeutic process was different for them as clients and they as therapists needed to work differently with that population of client.

P1 began his interview stating, "I say this all the time, I wouldn't be able to do what I do now without starting my career off working with people with disabilities." He credits the success of his career to his work with individuals with I/DD. P7 described feeling privileged to work with this population, especially witnessing their developing new skills:

> I'm just so appreciative of being given the opportunity to have these counseling sessions and how it helped him eventually go from being unemployed to holding a part time job for a long period of time, which if you can imagine enabled to him to use his skills that we talked about and have a level of like, social life that he hadn't had for a very long time because he was, this is during pandemic as well, and so now you're talking about some pretty big experiences working with this population.

In contrast, P8 described his reluctance to work clients with I/DD, noting his reaction when he is assigned new clients, "I'm kind of thinking like, I'm hoping that's not the case, because then it opens up this whole can of worms."

P8 described working with clients with I/DD and treating them with respect and speaking to them in a manner that they understand without being condescending:

> Because you have to get it down on a level that they understand without treating them as though they're stupid because they're not. They just learn differently, you know, that's the, that's the thing that drives me crazy about people is like, oh, I have to put, yeah, you have to put it basic, but basic in their terms. All of us need to know something basic.

P3 talked about working with the I/DD population and described how it made her feel good:

> I found love [for] the population and I left it for a while and worked in a nursing home and I found that I, I wanted to go back. Even when I was doing the work at

> the nursing home occasionally I, would, I would volunteer a friend of mine was running the Special Olympics. By the time I left, I was thanking them for the opportunity to go out there because no matter how bad life seems to us they are so much more positive oriented than we are, and we can learn so many lessons from them.

P7 talked about wanting to make a difference and find meaning in her work. She found that helping underserved populations. She described it as:

> I need to do something more meaningful. I was still getting my undergrad at that point, and I was like, I have always had this huge heart and passion for people who are experiencing homelessness, and I just really wanted to be a part of something where I could help them have a sustainable change in their life.

Some participants prefaced their descriptions of working with I/DD clients with cautious statements about not wanting to be understood as being critical or dismissive of the population and their needs in counseling. For instance, P8 prefaced a response with, "I feel like I have to, I don't want to sound bad, but like I feel like I have…" In her follow-up interview P8 further explained:

> This is gonna sound bad, but like I feel kind of like when I'm working with someone with Intellectual disability, like for me personally, I feel like it's kind of exhausting because I have to think a lot more and I always have to be kind of flexible in the moment. I don't feel like I'm doing my best work.

While not explicitly negative, there were participant statements that expressed an absence of regard, a kind of dis-regard. For example, P2 described having an inaccessible office space, saying, “And then I was like, oh well, I guess if someone comes in and they can't come upstairs, I'm going to do home visits because I don't know what else to do.”

Paternalistic Altruism

Paternalized altruism developed as a sub-theme after much revision throughout the coding process. Initially, paternalistic altruism was conceptualized as an independent theme and encompassed false regard and limiting. Paternalistic behavior within counseling occurs when a counselor acts in a way they deem to be in the client’s best interest as opposed to fully informing the client (Brace & VandeCreek, 1991). Altruism is acting in a way that is motivated by one’s own values and beliefs (Flasch, et al., 2019). Paternalistic altruism developed as participant meaning units reflected the desire to act in the client’s best interest while also acting from a place of selflessness. The theme was born of the statements from participants addressing holding clients in artificially high regard, behaving as though clients need special treatment and have inherent needs different from the rest of the population, and the counselor engages is for the client’s “own good.” Through thematic development, it became clear that paternalistic altruism was actually a sub-theme of regard, where participants described acting in what they felt was in the best interest of their client without the client’s input.

P7 described thinking clients with an I/DD “just” needed to feel seen and heard because they were often marginalized, saying, “I think they just, they honestly, if not all of them, I think they just needed this opportunity to feel seen and heard and many of them weren't."

Us Versus Them Thinking

A second sub-theme of regard is us versus them thinking whereby participants describe clients with I/DD as being different or those people as if the entire population of individuals with an I/DD can be placed into one group that is outside the rest of society.

Participants talked about the I/DD population as though they were their own class of people; it was not inherently negative or positive, rather it was a clear distinction between the I/DD community and the "rest of us". P1 talked about both his sister with Down Syndrome and his clients with I/DD as though he was a caregiver to them; somehow over them and able to monitor their behavior as though the population somehow needed guarding. He said, "I'm not going to let you get away with something because of you know, your, your intellectual disability." P3 discussed being surprised by how much clients with an I/DD can do. She stated, "OK, I mean it really enlightened me into how much that that population can do and they can be independent if the right supports are put in place and the right type of communication is given to them." P7 described clients with an I/DD as "the ones", saying, "Now the ones that came from voc rehab and I know we're really specifically talking about intellectual disability."

Theme of Encouraging

Encouraging was defined as the way participants described helping clients access services and move past barriers. Initially, encouraging was conceptualized as advocacy and policy; each participant discussed barriers to treatment in some form. However, advocacy and policy do not describe the lived experiences of the participants as they are in session with clients who have an I/DD. Advocacy is also a very well-defined concept in the counseling literature and so a different term was selected to describe this theme. In the development of encouraging, free imaginative variation was used to step back from my ideas and conceptualizations and consider the data from a variety of perspectives.

P1 described his experience working with clients who have an I/DD and encouraging them to reach their potential and not to limit themselves because they had been told because of their disability they could not do something. He said, “You might not be great at it, but it you know what? It's the old Henry Ford quote. If you think you can, you think you can't. You're right.” [The Henry Ford quote correctly reads “Whether you think you can, or you think you can't--you're right”]”. He further described encouraging clients to reach their potential, saying, “I'm like, “No. You can learn about yourself, you can learn how your brain works, and then you can work to create systems to deal with yourself.” P7 said that she did her best to make sure clients with I/DD had the services that they needed, reporting that, “All the same, I want to do the same thing for somebody who has some kind of intellectual disability.”

P2 described a client and family system where the client had an intellectual disability, and her mother was very involved with the client’s life; P2 discussed how he worked give the client autonomy and explained to the client’s mother how the client had rights despite the mother’s objection. P2 said, “And I said that I need to talk to the client.

So she was pretty annoyed with that. But then, the client and I, I think we have about as much rapport as we can get."

P7 explained:

> And my hope would be that all counselors, and I assume we get into this with that [results of the current study] right, like I would assume counselors will have that perspective, but I think what needs to be a part of the training is they're just as much of a human being. You know, so absolutely, absolutely.

Barriers to treatment and lacking treatment options were addressed within the theme of Encouraging. P2 explained how treatment options were limited in his state, saying, "So someone who had Medicaid would not ever see, like a private practice person in [state] because they would have, they would all their only choice was to go to [community mental health]."

P7 discussed the attitude toward mental health services and how the perceived value was less than that of other services for clients with an I/DD:

> Challenging because honestly, mainly because I had to go in there and try to convince vocational rehabilitation to get on board, which seemed like, you know, naive me, oh, they're going to see the value in this, but really a large proportion of them really didn't buy into it because we were trying to say it like, you know, we do all these, we provide all these other services.

Discrepant Data

P4 and P5 were not included in the data analysis because while they did initially appear to meet the criteria, in the interview process it was assessed that they did not fully meet the inclusion criteria. Despite not being included in the data analysis, both participants offered valuable insight. Participant responses often encompassed multiple themes within a single meaning unit. Participant interviews used in data analysis were only included one theme per meaning unit. However, since P4 and P5 were not included in data analysis, their responses can be used as examples of how multiple themes were present within a single meaning unit.

P4 was not included in the data analysis because although he stated he had more than 5 years' experience, it was revealed in the interview process a portion of that work was in the criminal justice system and not clinical in nature. However, P4 was the only participant that disclosed his own disability in the interview process. P4 offered an interesting insight into the clients with an I/DD are conceptualized in a counseling session. In describing work with a client with I/DD, P4 stated:

> You know, I'm surprised that's how insightful she is. You know, a lot of people have that assumption that when you're dealing with somebody with an intellectual or developmental disability, they're a little slow on the uptake. But, you know, that's not the case with her. She's, she's very insightful. Like she's able to respond to traditional CBT therapy.

He then went on to describe his own disability, saying, “I treat them like any other client I know. For myself, I always disclose my personal developmental disability, so a lot of times it will put clients at you know, a bit of ease.” P4’s description of his client encompasses Comparing, Joining, and Competence within one meaning unit.

P5 was not included in the study because although in the screening call she stated she had experience with disability, it was not counseling experience. She worked within the prison system with inmates preparing to transition to community control from incarceration. Her perspective of working with individuals with I/DD was aligned with the perspective of other participants when discussing the connection with individuals with I/DD. P5 said:

> And you start to form these bonds and it's like, there's this therapeutic connection and it's like, it takes extra work, but once it's once it's established, it's established. You've got to have that human connection before you start doing anything.

P5 also offered the unique perspective of having been a para-professional and having to meet the needs of clients with I/DD with no training. She explained how the clients would want to see their counselors but they were inaccessible, saying:

> And the kid would be like asking to talk to them [counselor] and like asking for help because they … trying to, yeah, have their needs met and they wanted to talk to their like their counselor and their counselors would be very, distant.

Synthesis of Participant Experience

The final step in Giorgi's (2012) descriptive phenomenological method is a synthesis of the data. In the current study that was the lived experience of counselors working with clients who had an I/DD. In this last step the data can be analyzed and interpreted (Giorgi, 2012). Giorgi (1997) explained that the need for interpretation in phenomenology was not clear; there is certain a place for description and analysis within phenomenological research. In the results section the data were analyzed by theme and samples of the descriptions provided by participants were used to explain the meaning of the themes that emerged throughout the coding process. Each participant described their own unique experience being in session with a client who had an I/DD and a synthesis of the lived experience of being in session with an I/DD client is discussed.

When a counselor sits in session with a client with I/DD, they may be anxious and unsure of how to build a therapeutic relationship with the client and be curious about the client's capabilities for talk therapy. Counselors compare their I/DD clients' abilities with those of other clients and make decisions about treatment possibilities based on these comparisons. Due to an expressed lack of education and training within their graduate programs, participants describe relying heavily on their outside experience with disability to guide them in session. Disability experiences come from personal experiences, such as a family member or friend with an I/DD, as well as professional experiences such as case management with the I/DD population.

Themes frequently interacted with each other and included the expression of themes. The amount of competence a participant perceived themselves to have was connected to their expressed ability in making connections with clients seen in joining. An additional example of this is the subtheme us versus them thinking in regard and bridging within the theme of joining. If a client was conceptualized to exist cognitively in a different space from the rest of the population, then it would be necessary to bridge that gap and find a way to connect to the client.

Summary

Common themes among established counselors working with clients who had I/DD were competence, joining, comparing, regard, and encouraging. Subthemes also emerged within themes. These themes were derived from rich and detailed descriptions of participants' lived experiences. While there were common themes across participants, it is important to consider that lived experiences involving the phenomenon are unique to each participant (Giorgi, 2012).

Chapter 5 includes a discussion of findings, limitations of the study, recommendations for further study, and implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this descriptive phenomenological study was to describe the lived experience of established mental health counselors working with clients who have an I/DD. The main tenant of phenomenological research is the suspension of judgment within the research in order to truly understand the nature of the lived experience (Giorgi, 2012). Understanding the lived experience of counselors working with clients who have an I/DD could provide insight into the difficulties counselors face when working with clients who have an I/DD. Additionally, the findings of the current research could help to inform established counselors and counselor educators about the needs of counselors when working with the I/DD population. This chapter provides an interpretation of the findings from both thematic and participant perspectives, a discussion of further research, and the social change and justice implications of the current study.

Interpretation of the Findings

Phenomenological research requires the suspension of judgment of the researcher, or bracketing, and allows the descriptions of the participants to be the focus (Giorgi, 1997). Giorgi further described the sensitivity of the researcher to the perspective of their specific discipline. Each participant had a unique perspective but also contributed to themes that were reflected in the interviews across participants. I am a doctoral student charged with learning as much about research and research methodology as possible. While reflective processes are not specifically part of Giorgi's methodology, they are part of phenomenology and were used in this study as part of the analysis. The reflective process occurs in phenomenological research when journaling occurs alongside the data analysis. Vicary et al. (2017) discussed the value of reflective journaling for doctoral students engaging in data analysis for the first time.

Reflective journaling can also enhance validity in the research (Vicary, et al., 2017). I used reflective journaling throughout the data collection and analysis processes. The journaling process allowed me to bracket my thoughts and suspend my own judgment when analyzing participant data. The contents of my journal were also used as the basis for discussions with my committee chair throughout the data collection and analysis process. My journal notes also helped form my sections on future research and social change.

While each participant had a unique experience with detailed descriptions of their experience, the data can also be synthesized as a whole to discuss the phenomenon of the experience of counselors sitting in session with clients who have an I/DD. Mental health counseling is an inherently client driven process (Whitehead & Purvis, 2023), yet participants often described sessions with clients who have an I/DD as being difficult to navigate, especially when joining with the client and establishing rapport. Participants expressed genuinely wanting to help their clients with I/DD but often described not having the education or resources to feel like they could best work. They described having to rely on outside experiences that were not counseling related for their disability competence. While participants described the outside experience as helpful, it was not adequate to give them the skills necessary to feel effective in sessions with clients.

Participants also described being overwhelmed and anxious when working with clients who had an I/DD, leading them, at times, to resist working with the population. The synthesis of current data and the thematic development is also supported in the existing literature.

Theme of Competence

Competence was participants' perceptions of their own abilities to provide adequate counseling services to clients with I/DD. Rivas and Hill (2018) found counselors in training feel unprepared to work with clients who have disabilities. Experiences of participants confirm that counselor education programs are not preparing counselors to work with clients who have disabilities. Counselor self-efficacy is enhanced by clinical experience (Larson & Daniels, 1998; Strike et al., 2004). Exposure to disability in a clinical capacity during education and training could therefore impact participants' disability competence.

Participants gave thick, rich descriptions regarding their concerns about being in session with I/DD clients and relying on outside experiences, adjusting the ways they traditionally engaged in counseling, and adapting their practices when working with clients with I/DD. Participants gave the most emphatic and descriptive responses when discussing their competence, often using descriptive and animated language.

The theme of competence was the main theme that emerged from this study. Participants often described sitting in sessions with clients and wanting to help but not knowing what to do to join with clients or how to encourage them. Participants also described having genuine regard for clients, but that regard did not translate into perceived competence.

Theme of Joining

Joining was c the way participants described establishing a therapeutic rapport and efforts to connect with clients. Participants described significant efforts to establish therapeutic rapport with clients and frustration associated with attempting to make connections with clients when they did not have an accurate understanding of clients' level of functioning. Participants described taking extra time to engage with clients without infantilizing them. Participants gave detailed descriptions of ways they worked to establish rapport and establish connections with clients, often using detailed analogies involving building a bridge or unlocking a door.

Participants described overall lack of effective treatment modalities for clients with I/DD. They did describe successful techniques for making initial connections with clients with I/DD, such as finding common interests to discuss. Participants then described issues involved with advancing the counseling process and frustrations associated with not knowing what to do next in sessions with clients with I/DD.

Participants described not knowing where to go next in sessions and the mental taxation involved with making sure clients were also tracking in sessions. Moments of dis-regard were also described by participants as they described not wanting to be in session with clients who had I/DD or avoided scheduling sessions for as long as possible to avoid their own discomfort of being in sessions.

Theme of Comparing

Comparing involved participants' conceptualization of intellectual and developmental disabilities among clients diagnosed as having I/DD, different forms and variations of I/DD, and how these impacted clients' abilities to be engaged in counseling. Participants specifically identified ASD as being different than other intellectual and developmental disabilities and less of a hindrance in terms of clients' participation in and benefits from counseling.

All participants described conceptualizing differences between disabilities and people with certain disabilities. Four participants said ASD was somehow different and not as severe as other I/DD. Intellectual disabilities, especially autism, fall on a spectrum that can vary from mild to severe (APA, 2022). However, participants characterized clients with autism as higher functioning compared to those with other kinds of I/DD. An accurate understanding of disability is necessary for effective work with clients with I/DD (Larson & Daniels, 1998). This understanding may help to bridge the knowledge gap for counselors when working with clients who have I/DD.

The theme comparing also included participant descriptions of the differences between working with clients who had an I/DD and clients who did not. Participants described being told by supervisors and colleagues to use behavioral counseling with clients with an I/DD and to meet the client where they were developmentally without further guidance on how to engage in counseling. Participants described feeling as though clients with I/DD were put into boxes and only certain theoretical orientations applied to this population, whereas there were unrestricted options when working with clients without I/DD.

The theme of comparing also included participants’ acknowledgment of the judgement placed on clients with an I/DD, and recognition of the widespread lack of education and training for counselors to work with clients with I/DD. Comparing was not always done in a negative tone; participants also described the extra time and attention that they gave to clients with I/DD, the internal self-talk about how to approach sessions, the creativity used in joining with clients and establishing rapport, and the need to more attentive to the non-verbal cues of clients with an I/DD. While participants often described the extra time and attention it took to be in session with a client with an I/DD, they strived to accept clients as whole individuals deserving of respect and effective counseling. Whitehead and Purvis (2023) conceptualized autism as a failure to individuate and propose person-centered therapies as a primary treatment modality, suggesting traditional behavioral therapies associated with autism reduce opportunity for affective expression. This call for a humanization of autism through counseling approaches that attend to the whole person is in line with and supports the findings of this study regarding participants’ perceptions of their work with I/DD clients.

Theme of Regard

The overarching meaning of the theme regard is the way participants think about their clients with I/DD, positively and negatively. Participants often described regard for their clients with I/DD; descriptions of clients and client interactions yielded the most detailed and rich descriptions among participant responses. Participants spoke of their previous experience and exposure to the I/DD population with admiration and appreciation and how that translated to their conceptualization of current clients. Regardless of the regard participants expressed about clients, it did not translate to high levels of competence. Participants described valuing clients while still feeling as though they were ill-equipped to provide adequate counseling. Participants often spoke of working to establish rapport with clients and provide developmentally appropriate services, while also describing their internal self-talk as not being confident in their ability to work with the client. Participants also described not having the necessary educational experiences to be fully prepared to work with clients with an I/DD.

While participants expressed motivations of care and selflessness, they also expressed a sense of knowing what was best for the client. Within the theme of regard, the subtheme paternalistic altruism developed as participant meaning units reflected the desire to act in the client’s best interest but doing so in ways that limited the clients’ choices and autonomy. Paternalistic altruism as also included participants holding clients in artificially high regard; behaving as though clients need special treatment and have inherent needs different from the rest of the clinical population. Participants described their clients with an I/DD as being different than clients without disability and that alone made them more worthy of being held in high regard as if they were fragile and needed protecting. This conceptualization of disability is primarily aligned with the Medical

Model, which stigmatizes clients with disabilities, specifically those with cognitive disabilities (Rivas & Hill, 2018).

The current study focused solely on the experience of counselors working with I/DD clients where participants gave detailed descriptions being in session with clients and wanting to do what was best for them but not always knowing how. Participants described doing what they thought was best for their I/DD clients even when, for example, the client could not be active part of that decision making. Participants held the view that their I/DD clients could not always help themselves, so they had to be helped by the participant. Brace and VandeCreek (1991) discussed this paternalistic behavior as the desire to act on behalf of their client even when done in the absence of full consent. I also found that participants described altruistic feelings when working with clients with an I/DD that was different from the paternalism described by Brace and VandeCreek (1991). The descriptions included details about going out of their way for clients with I/DD in attempts to make connections and provided adequate treatment.

Participant descriptions of regard for clients was seen on both sides of the continuum, being both positive and negative. While most participants described holding their clients in high regard, there were instances where clients with I/DD were described with disregard. This dis-regard was often related to an inability to join with the client or difficulty finding ways to encourage them within sessions.

Theme of Encouraging

The theme encouraging means participants' perceptions of systemic, practical, and attitudinal barriers facing clients, as well as their efforts to help clients' access services and overcome barriers. Encouraging emerged as a theme in participants' descriptions of their efforts to motivate their I/DD clients, and caregivers, to engage in the counseling process or navigate barriers within their lives. Further analysis showed the theme of encouraging also included participants' efforts to help clients make changes but that fell short of true advocacy for policy change. Participants often described attempting to help their clients with I/DD navigate the different systems associated with disability services and participants' frustrations at the barriers clients faced. Participants clearly described perceiving the barriers as flaws in the systems in which the clients were forced to interact and not as evidence of the clients' flaws or limitations. Encouraging also included participants' perceptions of the attitudes held by other professionals or promoted at agencies about working with I/DD clients, and participants' attempts to change peers' understanding of and attitudes toward the population. Participants challenged the idea that I/DD clients I/DD are adequately served by counselors-in-training, interns, or paraprofessionals. Participants also perceived that their own outside or prior experience with individuals with I/DD gave them insight and a level of comfort working with I/DD clients that their peers lacked.

The SMD is based on the belief that barriers individuals with disabilities face are due to societal norms about disability and not the disability itself (Swain, et al., 2003).

That participants perceived the systems, and not their clients, as flawed suggests participants' conceptualization of I/DD clients is in line with the SMD. The SMD gives more perceived control over circumstances than the Medical Model of Disability (Oliver, 2013). In the SMD, barriers are viewed as evidence of inadequate systems and of the larger society's inability to meet the needs of those with disabilities. Participants described working to encourage their clients to navigate through those barriers. Given participants' lack of education or training in working with I/DD clients, this finding suggests the ability to see I/DD clients as vulnerable individuals in a flawed and limited system is the result of the individual counselors' outside or prior experience.

Encouraging was connected to competence in many participant descriptions, suggesting a strong link between the two. Participants spoke about wanting to be able to create meaningful change for their clients but lacking the necessary education and training to do so effectively.

Participant Synthesis

While each participant had their own unique experience of being in session with a client with an I/DD, themes carried across participants. All participants (n = 6) discussed the themes of competence, joining, and comparing and most participants (n = 5) discussed regard and encouraging. The themes interfaced in ways that demonstrated a link between how participants perceived their own disability competence and their regard for I/DD clients. The conceptualization was based largely on previous experience with the I/DD community, suggesting those experiences influenced the regard participants had for I/DD clients. Participants who discussed their competence working with clients with I/DD expressed more effort in attempts to join with clients and in their regard for clients. Participants who described a lack of perceived competence were more dismissive toward clients with I/DD and less encouraging towards clients with an I/DD, describing them as not being fully capable of participating in the counseling process. Synthesis of each participants' experience and the interpreted meaning of that experience are presented here.

P1

P1 described his experience working with clients who have an I/DD with positive regard and frequently used the metaphor of building a bridge into a client's world to establish rapport. When describing being in a session with a client with an I/DD he spoke about the need to build a bridge and access the client's world. His descriptions of client interactions included several examples of his effort to connect to clients, using techniques that the client related to; he specifically used examples that the client could relate to. P1 frequently mentioned his sister who has Down Syndrome when discussing his perceived competence working with the I/DD population. His competence was heavily influenced by his early experiences with his sister and his early professional experience working as a case manager for clients with I/DD. His positive regard for individuals with I/DD is clear throughout both of his interviews.

P2

P2 described reflecting on both the screening questions prior to his interview and the interview itself prior to his follow-up interview; in both cases he explained that he did not typically consider disability competence in his practice. P2 said that all of his perceived competence working with clients that have an I/DD came after he became a professor and, he described seeking supervision from colleagues when working with clients with I/DD to address his own perceived lack of disability competence. He described feeling unprepared and overwhelmed when he was in session with a client with an I/DD; he said that he often felt like he didn’t know what to do next. P2 had little interest in working with the I/DD population in clinical practice and was dismissive towards their needs.

P3

P3 described her previous experience as a case manager for people with disabilities across multiple states and types of facilities. She credited her work as a counselor as being from her previous experience. Her previous experience was the central theme to her replies. She said that for her being in a session with a client with an I/DD was much like case management, but the topics were slightly different. She described multiple situations where her positive regard for clients was clear, and her descriptions idolized the I/DD population. She talked about what she has learned from her I/DD clients and how they have changed her life, often switching between the themes of Joining and Regard in her responses.

P6

P6 discussed working with clients with an I/DD as though they were making choices about their willingness or ability to participate in counseling. She discussed how working with clients with I/DD was challenging and frustrating; she described the extra work that went into sessions and the attention I/DD clients required between scheduled sessions. She described how she had to over-simplify sessions for clients to be able to participate. She discussed previous experience working with I/DD clients as though it was a burden because of the additional effort that was needed. P6 did discuss efforts made in session to develop rapport with clients but placed the potential success of those attempts on the client; it was unclear if this was related Regard, Joining, or Encouraging, as all three themes were part of her answers. When discussing clients P6 expressed both negative and positive aspects of Regard toward clients, often appearing conflicting in her conceptualization of the population.

P7

P7 described the different skill sets necessary to effectively sit in a session with a client with I/DD. She described the need to establish client rapport on a developmentally appropriate level and to do it in a respectful way. Throughout her interview, P7 prefaced statements to not be offensive and spoke about making sessions simplified and developmentally on target for her clients with I/DD. She was quick and careful to say that she did not want to offend her client with the description or actions, indicating her regard for the client but also paternalistic altruism as she worked to do what she thought was best for client without fully explaining it to the client. Her perceived competence working with I/DD clients was built working through vocational rehabilitation where a high level of regard was maintained. She described frequently encouraging colleagues and clients to ensure the more appropriate services for clients.

P8

P8 described being in session with a client with an I/DD as being difficult because her training did not prepare her to work with the population. She described being in session as very difficult and overwhelming. She discussed all of the extra things going through her head that she did not have to attended to when working with a client without a disability. She also said she found herself hoping a client did not have an I/DD. P8 had a high level of regard for I/DD clients and expressed the need for clients with I/DD to receive more specialized services than they did. P8 cited her own perceived lack of competence when working with the population.

Limitations

It is difficult to generalize qualitative research because it examines the unique perspective of individuals (Patton, 2015). This is especially true in phenomenological research design when the goal of the research is to capture the rich and detailed descriptions of the participants as they experienced the identified phenomenon (Giorgi, 2012). Limitations were managed and accounted for in the current study as much as possible but there are limitations to the study, influenced by participant demographics, researcher bias, and sampling strategies.

The current study initially sought licensed mental health counselors for the study, but a lack of participants led to the inclusion criteria to be expanded, with IRB approval. Final inclusion criteria were a master's degree in mental health or a related field regardless of licensure. The current study included six participants in the data analysis and while there was saturation of the data, transferability is often limited by small sample studies in qualitative studies (Patton, 2015). The study's final participants included 3 licensed mental health counselors, a licensed clinical social worker, a licensed marriage and family therapist, and a registered mental health counselor intern. While all participants had master's level training, the perspectives of different disciplines (e.g. social work, mental health counseling, and marriage and family counseling) can be different and therefore not reflect purely the experience of mental health counselors.

Researcher bias is always a concern in qualitative researcher. While steps were taken to reduce bias, I am a new researcher and the likelihood for unintended bias is possible. I took steps to reduce bias during the interview process by using free imaginative variation where I purposely considered different perspectives without judging those perspectives to be right or wrong. I used reflective journaling to track my thoughts throughout the data collection and analysis process to separate my thoughts from the need to suspend my own judgment in the phenomenological method. I also discussed opinions on participant interviews with my committee chairperson to limit and resolve any bias that came through in the data analysis.

The quality of interview data may have led to limitations within the study. The goal of phenomenological research is to capture the lived experience of the participants (Giorgi, 2012). At times participant responses were short and not well developed, leading to meaning units that were not well-formed. This could be due in part to my own inexperience as a researcher and interviewer, as well as the participants being uncomfortable with the interview process. Due to the participants own expressed lack of perceived competence it may also be that Participant discomfort may also have led to shorter, less-developed answers in the interview than what was initially expressed in the screening call.

Recommendations for Further Research

People with disabilities make up the largest minority population in the U.S. and approximately 1% of the U.S. population has an intellectual disability (CDC, 2017). There is a high likelihood that a counselor will encounter a client with an I/DD. The current study has demonstrated that counselors are not fully prepared to work with clients who have an I/DD. With participants who expressed low perceived disability competence, it was difficult to assess if it was an issue of competence or an issue of regard. A lack of competence may contribute to a lack of regard, but the converse may also be true. A quantitative study into the relationship between disability competence and client regard could help to answer this question.

Participants discussed their outside experiences and described how those experiences significantly impacted their perceived level of disability competence. Larson and Daniels (1998) noted the importance of experience in the development of self-efficacy, reporting that experience is positively correlated with an increase in self-efficacy. Since the disability competence literature consistently notes the lack of training and education for counseling disability, a study examining what experiences most influence disability competence could be illuminating for educating future counselors. Future research could also explore if those experiences could be created for future counselors in training; preparing counselors to work with clients with I/DD in real-world experiences such as in field site specific to clients with an I/DD.

Mental health counseling and rehabilitation counseling have inherent differences, but still fall squarely within the helping professions. Evans (2017) and Rivas (2017) supported the need for further study into disability competency in both mental health and rehabilitation counseling. A comparative study between mental health and rehabilitation counselors could help to illuminate strategies that are currently successful in building disability competence.

Counselor conceptualization of disability could provide insight into how counselors view clients who have an I/DD. Swain, et. al (2003) and Oliver (2013) discussed the humanization of disability the SMD provides as opposed to the Medical Model. Reconceptualizing disability could create changes within all facets of mental health treatment for clients with an I/DD. Competence surrounding appropriate interventions, strategies for joining and forming connections with clients, and the best way to encourage clients are potential areas of further study. The current study indicates the way a counselor thinks about disability has an impact on their therapeutic intervention with the client. A study into the model of disability counselors use could help define the broader way disability is conceptualized.

Implications for Social Change

Social change and social justice are needed within counseling and counselor education. The ACA (2014) cited the importance of working toward social chance and the movement towards a more just world. The current study has several implications for social change including establishing enhanced counseling practices for clients with an I/DD, and changing the perception and attitude toward individuals with I/DD. Participants in the current study frequently described efforts to encourage clients within sessions and described their own internal self-talk as they tried to develop ways to make connections with clients with an I/DD. While this encouragement is important to the therapeutic process, it does not rise to the level of advocacy and the facilitation of systemic change.

By enhancing the counseling practices for clients with an I/DD these individuals could be afforded the same opportunity their non-disabled peers have. Currently, access to mental health treatment is often limited and the need is assumed to behavioral in nature. There is limited literature regarding the relationship between disability and counseling. Mental health counselors need to be more prepared to work with clients who have disabilities (Evans, 2017; Forber-Prattet al., 2018; Huber et al., 2017; Rumrill et al., 2019). The current study highlights the need for disability competence when working with clients with an I/DD.

The addition of disability concepts to the 2024 CACREP Standards will change the way future counselors are educated about disability. However, the current study has helped to highlight that, regardless of how much regard a counselor has for clients with an I/DD, how well they are able to join with and encouraging those clients, or if they are able to limit comparing clients to their non-disabled peers, that is not an indication of high levels of perceived self-competence. A counselors may have the best of intentions but the necessary skills to provide counseling to clients with an I/DD.

Whitehead and Purvis (2023) discussed a return to the humanization of autism as opposed to the modern biological medical model that has been used in recent decades. Whitehead and Purvis (2023) discussed treating the cause of behavior, not the surface behavior, and call for attending to the affective, emotional needs of the client that are often dismissed in behavior therapy. This is in contrast to the current biological medical model of autism that treats the disorder as a brain disease treatable with medication and behavior modification (Whitehead and Purvis, 2023). While the authors state they are not trying to invalidate the use of medication management or behavior therapy for the treatment of autism, there is a clear call for a more holistic approach to treatment. This call for change can apply to all clients with I/DD and is supported by participants in the current study describing behavioral counseling techniques as the option for treating clients with I/DD. This move towards reconceptualizing autism in a more humanistic way can be used alongside person-first counseling models to enhance mental health treatment for the autistic community and potentially the I/DD community at large. The current study found that us versus them thinking was common among participants, demonstrating a need to humanize the population and bring the focus to individualized treatment. Whitehead and Purvis address this concept as a lack of individuation when autism and other disabilities are treated as the disorder rather than the person; the focus becomes treatment for the disorder rather than the person with the disorder. A return to a more humanistic way of thinking about I/DD takes away the us versus them thinking and makes the focus on the unique individual regardless of disability. This attitude may be due to the overreaching societal perception of individuals with I/DD as being somehow less-than or not as capable as their non-disabled counterparts.

There is a need within the counseling and counselor education community to equalize the treatment of individuals with I/DD. There is an opportunity for counselors to begin to change the narrative surrounding the perception of individuals with an I/DD.

Conclusion

There is a need for disability competence among mental health counselors. This need is only going to grow as disability grows within the United States. The current study of the lived experience of counselors working with clients who have an I/DD confirms lack the education and training among counselors necessary to effectively work with this population. The current study has added to the existing literature on the need for disability competence and what helps to shape that competence.

While it is reasonable to expect disability competence to increase among developing counselors as the 2024 CACREP Standards are implemented, continued research will be necessary to assess training effectiveness. Perhaps more challenging are the cultural and societal attitudes toward disability. In the current study, these attitudes surfaced as paternalistic altruism; while well-meaning, such perceptions may limit counselor effectiveness. With future research, there is an opportunity to enhance the learning experiences of student counselors to include disability-related experiences, as well as continuing education opportunities for established counselors. There is an opportunity to change the conceptualization of clients with an I/DD to a more inclusive and equal role in society.

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Appendix A: Solicitation Email #1

RE: Research Study: Working with Clients who have Intellectual Disabilities

Dear XXX,

I hope this email finds you well. I am contacting you today because, as part of my doctoral work, I am interested in interviewing experienced counselors who have worked with at least one adult client diagnosed with an intellectual disability. The goal of my research is to improve the way counselors are trained to work with clients who have disabilities.

If you are interested in participating in my study, please reply to this email. I will contact potential participants by phone for a brief screening after which qualified counselors will be scheduled for a 45-50-minute video interview at a later date. The entire time commitment will be less than 60 minutes.

Given the relatively small pool of counselors with relevant experience in our region, I am also relying on word of mouth from clinicians and supervisors such as yourself to find participants. If you have recommendations of other counselors who you think may have relevant experience working with this population, I would greatly appreciate it if you would send me their names and contact information. Alternatively, please feel free to forward this invitation to others believed to meet the inclusion criteria.

Two additional reminder emails will be sent over the next two weeks. Please let me if you would rather not receive further communication and I will remove you from my contact list. All participation, including providing potential participant contact information is voluntary. Thank you in advance for your support in this process. If you have any questions or if I can provide additional information, please reach out via email at margarete.denk@waldenu.edu.

Sincerely,
Maggie Denk
Doctoral Student
Walden University
Counselor Education and Supervision

Appendix B: Solicitation Email #2

RE: Research Study: Working with Clients who have Intellectual Disabilities

Dear XXX,

I hope this email finds you well. I am following up on my email from last week regarding my dissertation research. As part of my doctoral work, I am interested in interviewing experienced counselors who have worked with at least one adult client diagnosed with an intellectual disability. The goal of my research is to improve the way counselors are trained to work with clients who have disabilities.

If you are interested in participating in my study, please reply to this email. I will contact potential participants by phone for a brief screening after which qualified counselors will be scheduled for a 45-50-minute video interview at a later date. The entire time commitment will be less than 60 minutes.

Given the relatively small pool of counselors with relevant experience in our region, I am also relying on word of mouth from clinicians and supervisors such as yourself to find participants. If you have recommendations of other counselors who you think may have relevant experience working with this population, I would greatly appreciate it if you would send me their names and contact information. Alternatively, please feel free to forward this invitation to others believed to meet the inclusion criteria.

One additional reminder email will be sent over the next weeks. Please let me if you would rather not receive further communication and I will remove you from my contact list. All participation, including providing potential participant contact information is voluntary. Thank you in advance for your support in this process. If you have any questions or if I can provide additional information, please reach out via email at margarete.denk@waldenu.edu.

Sincerely,
Maggie Denk
Doctoral Student
Walden University
Counselor Education and Supervision

Appendix C: Solicitation Email #3

RE: Research Study: Working with Clients who have Intellectual Disabilities

Dear XXX,

I hope this email finds you well. I am following up on my email from last week regarding my dissertation research. As part of my doctoral work, I am interested in interviewing experienced counselors who have worked with at least one adult client diagnosed with an intellectual disability. The goal of my research is to improve the way counselors are trained to work with clients who have disabilities.

If you are interested in participating in my study, please reply to this email. I will contact potential participants by phone for a brief screening after which qualified counselors will be scheduled for a 45-50-minute video interview at a later date. The entire time commitment will be less than 60 minutes.

Given the relatively small pool of counselors with relevant experience in our region, I am also relying on word of mouth from clinicians and supervisors such as yourself to find participants. If you have recommendations of other counselors who you think may have relevant experience working with this population, I would greatly appreciate it if you would send me their names and contact information. Alternatively, please feel free to forward this invitation to others believed to meet the inclusion criteria.

All participation, including providing potential participant contact information is voluntary. Thank you in advance for your support in this process. If you have any questions or if I can provide additional information, please reach out via email at margarete.denk@waldenu.edu.

Sincerely,
Maggie Denk
Doctoral Student
Walden University
Counselor Education and Supervision

Appendix D: Social Media Post

As part of my doctoral work, I am interested in interviewing experienced counselors who have worked with at least one adult client diagnosed with an intellectual disability. The goal of my research is to improve the way counselors are trained to work with clients who have disabilities.

If you are interested in participating in my study, please email me at margarete.denk@waldenu.edu. I will contact potential participants by phone for a brief screening after which qualified counselors will be scheduled for a 45-50-minute video interview at a later date. The entire time commitment will be less than 60 minutes.

Feel free to share this post on your social media platforms as well.

Appendix E: Screening Questions

1. Are you currently a mental health counselor, regardless of licensure status?
2. What year did you graduate from a counselor education or related program?
3. Was your program CACREP accredited?
4. Have you been in practice for at least 5 years?
5. Have you worked with at least one adult client over the age of 22 with a diagnosed intellectual or developmental disability?

Appendix F: Interview Questions

What is the experience of established counselors when working with clients who have intellectual or developmental disabilities?

1. Describe your experience working with clients who have I/DD.
2. Describe the experience of being in session with a client with I/DD.
3. Describe an experience that has influenced your disability competence.

Appendix G: Participant Email Regarding Study Results

Dear Research Participant,

Thank you again for participating in my study “The Experience of Established Mental Health Counselors Working with Adults who have Intellectual Disabilities”. The study was a phenomenological design seeking to understand the lived experience of counselors being in session with clients who have intellectual or developmental disabilities (I/DD). Several themes emerged throughout the study regarding the way counselors conceptualized clients, the manner in which they engaged with clients, and their perceived competency to work with clients who have an I/DD.

When a counselor sits in session with a client with I/DD, they may be anxious and unsure of how to build a therapeutic relationship with the client and be curious about the client’s capabilities for talk therapy. Counselors compare their I/DD clients’ abilities with those of other clients and make decisions about treatment possibilities based on these comparisons. Due to an expressed lack of education and training within their graduate programs, participants describe relying heavily on their outside experience with disability to guide them in session. Disability experiences come from personal experiences, such as a family member or friend with an I/DD, as well as professional experiences such as case management with the I/DD population.

If you are interested in obtaining a copy of the full manuscript, please contact me at margarete.denk@waldenu.edu.

Respectfully,
Maggie Denk
Doctoral Student
Walden University
Counselor Education and Supervision

Appendix H : Participant Follow-up Email

Dear XXX,

Thank you for your participation in my dissertation research. Below you will find a link to information about working with clients that have intellectual disabilities. Please do hesitate to reach out if you have any questions.

Additionally, at the conclusion of the study you will receive an email with the results. If you are interested in reading my full dissertation, please let me know via email.

Working with Clients with Disabilities: Implications for Psychotherapists
https://societyforpsychotherapy.org/working-with-clients-with-disabilities/

Respectfully,

Maggie Denk
Doctoral Student
Walden University
Counselor Education and Supervision

Appendix I: Participant Interview Example

[redacted]

So I think it probably gave you a little indication that recording has started.

Yep.

Something that said that I was recording? OK, so you can see that it's recording. Well. We'll jump right in, so. Describe your experience working with clients that have intellectual disabilities.

Ohm. Multiple people on the autism spectrum.

OK.

So. [pause] I. So helping them navigate. You know, I actually am working with two adults on the spectrum right now.

One is starting a business, the other is just trying to hang on, working with, trying to understand people and the social dynamics and things like that. So. Those two are pretty interesting. Umm. You know, I can't say I've had like… [pause] Yeah, it's been people in the autism spectrum. People with like regular developmental disabilities don't come in for therapy.

As far as the autism spectrum stuff, is that something that you put out there that you do and specialize in, or is it people that walked in the door?

No, I don't. I don't put. Yeah, I don't put anything out there, but if somebody calls, I've been like, I've been working people on the autism spectrum since '97 so.

OK. So hot a hot minute. So if somebody has OK.

So, I mean it's and all that stuff is like on my, on my CV if people, you know, look because I did, you know, case management with people with developmental disabilities. Umm.

So. So you said that that that the two were quite a. That was quite an interesting thing. Describe being in a session. What that's like.

Ohm. OK, so. And then the one guy that I'm talking with that's starting his own business, he worked in the government sector for years and so now he's doing stuff to like help people like. He created a business to help people deal with government stuff and get information from the government. And so we're talking about this. You know his website and getting people and so I told him that, like, "your upside look great, but there's no emotional thing there to get people to buy". So it's teaching about his brain and how. You know. "People don't make decisions based completely on rationality. That it's your emotional side of your brain that makes

decisions, and this light bulb went off in his head like, what?"[client] "Because, like, rationality is how I make all my decisions" "And I'm like, not exactly." And he was just like. [client] "It's like that makes things so much easier. I never even considered it that way." But then, like, he doesn't understand it so much. And so then, you know, we're talking about how to. You know, work through that and stuff like that.

So does it feel like traditional therapy when you're in that setting or in that situation?

With him, yes.

Follow-Up: What about working with that client felt like traditional therapy?

OK. What about the one that's just trying to hang on?

Yeah, he. Really nice guy and he just he over over overthinks things. And then what happens? Is he his self-esteem just goes down. And then and then he just wants to retreat into a shell.

OK. Umm. Still kind of traditionally therapeutic, like the same kind of thing you would do or.

Yeah, no. And then you made me think I'm seeing another guy. He's in college. And. He doesn't talk much. And so. We and and we just had to switch to online and I didn't think it was gonna work, but we played chess. And and I'm able to get through to him by playing chess.

I got to know this. I gotta. I gotta hear this.

Well, I mean chess is complex, right? And and so that I relate social situations to chess and how you got to think through your moves. And have a plan on how you're going to do it, and then you gotta adjust because your opponent isn't always going to follow according to your plan.

OK. And is he is he on the spectrum too?

Follow-Up: So what is it like for you in those sessions when it's not like traditional therapy? What's going through your head?

Oh yeah, he's. And and he's so limited socially and then he gets so frustrated that he just shuts down. Because he doesn't understand. And so then so then using the game of chess and how? You know it's. He doesn't mind losing a game of chess because he always learned something. And I'm like, "Gee, does that sound like life?" [client] "Ohh yeah, kinda."

OK. So taking just stuff that you already have to be able to adapt it.

Yep.

Follow-Up: What things are you adapting as you're in those sessions?

What? As far as disability competence goes. What has influenced or impacted your your disability competence?

Well, I have a sister with Down syndrome so. I just. I think for me, growing up with some, uh, sister with Down Syndrome. Just saw it as normal, not this different thing. And then, being the little brother, I never let her get away with anything because of her quote unquote disability. I remember like as a kid because she's only like 4'11'' And we, you know, we like most people,

we put the cereal on top of the fridge and there would be days would be like, can you get the cereal for me and I was like, you know where the step stool is. That's funny. OK, yeah, things like that where I just I'm not going to let you get away with something because of you know, your your intellectual disability. That. It's so then that's been always my approach. With people with disabilities, hey, you know you have gifts and abilities. Let me let me get to know you and find out what they are. And and we'll go from there.

And so you obviously you can't take that experience away as you grew up. But then you went on to grad school, became a therapist. Did. Did grad school for you prepare you to work with people that had disabilities?

No.

Follow-Up: Are there times in sessions where you find yourself “not letting [a client] get away with something”?

Have you ever found continuing education or what in continuing education, is there stuff that you've come across? Disability.

Only things on the autism spectrum. I have never seen anything about, you know, working with people with intellectual disabilities. Yeah, I've never seen training. So. Now I will say, I mean, yeah, because when I did case management in Chicago, you know, I would, I would attend the RNC convention every year, OK? You know. But. And there. There was a lot of good information, but it fit more social worky type of. Stuff. Not, not counseling and therapy, OK? So and I remember taking, you know some of my clients to see therapists in Chicago and, yeah, none were like super great at working with our people.

OK. And that was you started doing that in 97, is that what you said? OK. How long did you do that for?

Uh, I was. I was in Chicago doing that till 2006.

OK, so just under 10 years? And through that entire time, there was never someone who was like, wow, this therapist is amazing at this population.

Yeah, no.

Anything else come to mind?

I. I've read an article recently. Or I don't know what it was, but talking about ABA therapy. Yuck. And how people on the spectrum, umm as adults look at as like almost. Umm

Interesting. OK.

And I was like, wow. Because I I've never been a huge fan of ABA therapy. I'm back to you know more trying to understand the person, not just not just your behavioral object.

Sure.

Especially with autism like my my philosophy has always been. Umm. They live in their world, and they, they will visit ours when they when they want to or they have to. And my job is to build a bridge into their world, because if I do, then they're more likely to build a bridge back to me.

OK.

Because I can get. Because I know because when I do that and I and I've shown multiple parents how to do this. You know somebody on the spectrum, who doesn't speak a lot if you can connect with them. They won't shut up once you make that connection.

So where did that perspective come from? Where did this idea, where did that idea of "if I build a bridge to there, well, they're gonna build a bridge back to mine" come from?

You know, I made that click after I read the book, The Curious Incident of the Dog in the Nighttime.

OK.

Have you read that?

No, I've heard of it.

Yeah, no, I mean it it. You know, the story is written from the perspective of somebody on the spectrum, OK? And like, when I read it just clicked and like, oh, they live in their world. I I need to, I need to recognize that and. You know, build my bridge and they're more likely to. Meet me halfway and then telling them.

OK.

Here you must conform to the way things are and that just doesn't work. I mean even with, you know non-disabled people, you got to build a bridge to somebody because if you don't connect. Yeah, it doesn't work. So I'm always looking for in therapy with whoever I see is some connecting point because when once I do that make a connection.

Yeah, it works.

Yeah. No, it absolutely. I mean that's the whole, the whole therapeutic process, right. Yeah. Getting that connection. And that to me is the fun part of therapy is is you know. People, you know, parents are bringing the kid in, my kids a mess, you got all them out and I'm just like. Let's connect first. Yeah, not a problem. You know, we're like an ABA is like, you know, oh, this is the behavior and we need to do these things to stop the behavior. It's like the old thing of behaviors? Communication.

Follow-Up: How is it different for you trying to make that connection when the client has an intellectual disability?

Right.

And I think sometimes the people with disabilities. The only way that they're going to communicate is with that behavior. Yep. Yep. And to and and then it's it's just having the patience to do it. I mean, but that's the thing where. I mean, I started my career working in a group home with people with intellectual disabilities with behavioral issues. OK, so like, I had to learn how to be present with them because I was entering and I was looking at it as I was entering their world. Yeah. I wasn't there to make their life, you know? I wasn't the I don't know what you want to call it, but I'm like, I was a privilege for me to enter their world. This is their home. I needed to treat it as such.

Yeah. And what did you do? What? What? What? What was your goal?

When I started, I was direct care, OK? So. Changing diapers. Bathing. Teaching skills. All that fun stuff.

Thank you so much for doing this today.

It's no problem. You know, I wouldn't be and and I say this all the time, I wouldn't be able to do what I do now. Without starting my career off working with people with disabilities. Like learning to do life with people. You know, prepared me to be a counselor more than going to grad school.

Appendix J: Participant Interview Table Example

[redacted]

Line(s)	Meaning Unit	Psychological Statement	Theme
15-16	***So. [pause] I. So helping them navigate. You know, I actually am working with two adults on the spectrum right now***	P1 described the sessions with adults on the autism spectrum as helping them navigate.	Joining P1 described working with clients on the autism spectrum and how he views his role as helping them to navigate.
18-20	***One is starting a business, the other is just trying to hang on, working with, trying to understand people and the social dynamics and things like that. So. Those two are pretty interesting.***	P1 described two clients with autism he currently works with- one trying to start a business and another who struggles to understand people and the social dynamic involved. He described the clients as interesting.	Joining P1 conceptualized his role as helping clients to understand people and social dynamic. He finds the work interesting.
20-21	***Yeah, it's been people in the autism spectrum- people with like regular developmental disabilities don't come in for therapy.***	P1's work with intellectual disability has been adults on the spectrum and he has not seen other intellectual disabilities in his practice. He made a distinction between autism and other intellectual disabilities, which he referred to as regular disabilities	Judging P1's work with intellectual disability has been with those individuals on the autism spectrum and no other disabilities; he made the distinction between the two.
26-27	***No, I don't. I don't put. Yeah, I don't put anything out there, but if somebody calls, I've been like, I've been working people on the autism spectrum since '97 so.***	P1 explained that he does not advertise his expertise with disability but when asked by potential clients, he notes his long experience working with people on the autism spectrum.	Competence P1's clinical identity is shaped in part by his previous work with the I/DD community and his perceived disability competence.
31-32	***So, I mean it's and all that stuff is like on my, on my CV if people, you know, look because I did, you know, case management with people with developmental disabilities. Umm.***	P1 clarified that his curriculum vitae does list his experience working with people who have developmental disabilities.	Competence P1 indicated his knowledge and experience of working with people with disabilities is documented on his CV

37-42	***Ohm. OK, so. And then the one guy that I'm talking with that's starting his own business, he worked in the government sector for years and so now he's doing stuff to like help people like. He created a business to help people deal with government stuff and get information from the government. And so we're talking about this. You know his website and getting people and so I told him that, like, "you're upside look great, but there's no emotional thing there to get people to buy".***	P1 described a client with autism who is starting his own business. P1 pointed out to the client that while the website looked good, it lacked an emotional appeal to potential customers. P1 saw this as an example of how he, as a counselor, gives relevant, honest feedback to a client about the client's work, specifically on an aspect of advertising that the counselor understands the client may overlook, due to the nature of the client's disability.	Competence P1 described a client and how was able to give feedback to the client in a way that the client may have overlooked due to his disability but in a way that he was able to process and use the feedback.
42-50	***So it's teaching about his brain and how. You know. "People don't make decisions based completely on rationality. That it's your emotional side of your brain that makes decisions, and this light bulb went off in his head like, what?" [client] "Because, like, rationality is how I make all my decisions". "And I'm like, not exactly." And he was just like. [client] "It's like that makes things so much easier. I never even considered it that way." But then, like, he doesn't understand it so much. And so then, you know, we're talking about how to. You know, work through that and stuff like that.***	P1 explained how he educated his client about the way his brain works and the way others' brains' work. He explained how the client then began to be able conceptualize the alternative perspective, even though he did not understand it. P1 tried to help the client understand how others think and the role emotion plays in our decision-making processes, something the client may not fully understand.	Joining P1 described the process of educating his client on the way his brain works versus the way others' brains' work. He attempts educate the client to help the client understand concepts that he may not fully understand.
63-65	***And then you made me think I'm seeing another guy. He's in college. And.***	P1 discussed another client who was in college and does not use much verbal communication.	Joining

	He doesn't talk much. And so. We and, and we just had to switch to online and I didn't think it was gonna work, but we played chess. And, and I'm able to get through to him by playing chess.	When they needed to switch to virtual sessions, P1 was unsure if the format would be effective with the client, but was able to engage with the client by playing online chess with him.	
69-72	***Well, I mean chess is complex, right? And, and so that I relate social situations to chess and how you got to think through your moves and have a plan on how you're going to do it, and then you gotta adjust because your opponent isn't always going to follow according to your plan.***	P1 explained how he has compared the complexity of chess to social situations for his client He used the example of thinking through situations and having a plan, while also needing to remain flexible to adjusting to others' actions.	Joining P1 used examples the client is familiar with to explain concepts that are difficult for the client to understand.
74-77	***Oh yeah, he's. And, and he's so limited socially and then he gets so frustrated that he just shuts down because he doesn't understand. And so then so then using the game of chess and how you know it's [pause]. He doesn't mind losing a game of chess because he always learned something. And I'm like, "Gee, does that sound like life?" [client] "Ohh yeah, kinda."***	P1 described how the client is limited socially and becomes frustrated, shutting down when he doesn't understand social cues. P1 further described how he used the game of chess to help the client make parallels between the game and life. He explained how the client doesn't mind losing a game of chess because he learns something; P1 is able to equate that to life in a way that the client understands.	Joining
86-91	***Well, I have a sister with Down syndrome so. I just. I think for me, growing up with some, uh, sister with Down Syndrome. Just saw it as normal, not this different thing. And then, being the little brother, I never let her get away with anything because of her quote unquote disability. I***	P1 described growing up with a sister who has Down Syndrome as normal. He described his role as her little brother as never letting her take advantage of her "quote unquote disability," ascribing some doubt or disagreement with her disability status. He described a situation where his sister's short stature, a common characteristic of people with Down Syndrome, was	Paternalized Altruism P1 talked about growing up with a sister who has Down Syndrome and how as the younger brother he did not let her take advantage of situations by blaming her disability. He used quotes to describe her as having a disability indicating his

	remember like as a kid because she’s only like 4’11’’ And we, you know, we like most people, we put the cereal on top of the fridge and there would be days would be like, can you get the cereal for me and I was like, you know where the step stool is.	preventing her from reaching cereal boxes on top of the refrigerator. In response to her request for help, P1 recalled that he helped her solve the problem by reminding her where the step stool was.	view of her as being fully capable.
91-93	***Things like that where I just, I’m not going to let you get away with something because of you know, your, your intellectual disability. That. It’s so then that’s been always my approach.***	P1 discussed how he did not let his sister blame her disability and that carried into his clinical practice where he does not let client excuse behavior because of their disability.	Paternalized Altruism P1 described how in the same way he does not allow his sister to take advantage or use her disability as an excuse, he sets the same boundaries with clients.
93-95	***With people with disabilities, hey, you know you have gifts and abilities. Let me let me get to know you and find out what they are, and, and we’ll go from there.***	P1 described his approach to working with people with disabilities as seeing them as individuals with talents and abilities that may be hidden or not obvious to others. He described viewing it as getting to know the person and identifying these as the first step to working together effectively.	Joining P1 discussed the manner in which he views clients with I/DD as having talents and abilities. He described his mindset toward the I/DD population as being very capable once a connection was made, as though it was not obvious on the surface what their talents and abilities might be.
128-129	***I, I’ve read an article recently, or I don’t know what it was, but talking about ABA therapy. Yuck. And how people on the spectrum, umm as adults look at as like almost. [pause]***	P1 explained that he read some literature on ABA therapy and described his unfavorable reaction to it and the way it conceptualized adults on the autism spectrum.	Judging
133-134	***And I was like, wow, because I I’ve never been a huge fan of ABA therapy. I’m back to you know more***	P1 further explained that he has never liked the concept of ABA therapy, his conceptualization of people as going beyond their	Judging

	trying to understand the person, not just, not just your behavioral object.	behavior, and attempting to understand the person as a whole.	
138-141	***Especially with autism like my my philosophy has always been, they live in their world, and they, they will visit ours when they when they want to or they have to. And my job is to build a bridge into their world, because if I do, then they're more likely to build a bridge back to me.***	P1 described his philosophy on people with autism as living in their own world and visiting our world when they have a need or want. He further described his job using metaphor that as a therapist he must then build a bridge for the client so that the client can then build a bridge back. This concept helps him to connect to his client, making it more likely that the client will engage with him in return.	Joining P1 described the need to make a connection with clients before engaging in the therapeutic process. He likened it to building a bridge.
145-147	***Because I can get [pause]. Because I know because when I do that and I and I've shown multiple parents how to do this. You know somebody on the spectrum, who doesn't speak a lot if you can connect with them, they won't shut up once you make that connection.***	P1 described his confidence in the effectiveness of his approach and notes he has successfully taught a number of parents how to connect with their autistic child. He reported he has found that, once a meaningful connection is established, even low verbal autistic individuals will become very talkative, noting with humor, 'they won't shut up."	Competence P1 described his confidence in the effectiveness of his approach to working with clients with I/DD and how he has been able to teach parents how to form connections and engage with their children.
161-164	***You know, the story is written from the perspective of somebody on the spectrum, OK? And like, when I read it just clicked and like, oh, they live in their world and I I need to, I need to recognize that and you know, build my bridge and they're more likely to meet me halfway.***	P1 talked about the novel, describing how it is written from the perspective of someone on the autism spectrum. He described how it resonated with him that they live in their own world and he needed to recognize that and be the one to consider their perspective and then the client would be more likely to engage.	Joining
168	***That's better than telling them, "Here you must conform to the way things are". That just doesn't work.***	P1 discussed how the approach of telling clients that they must conform is not effective.	Judging
169-171	***I mean even with, you know non-disabled people, you got to build a bridge to***	P1 described how the process of establishing a connection is also necessary when working with	Joining

	somebody because if you don't connect. Yeah, it doesn't work. So I'm always looking for in therapy with whoever I see is some connecting point because when once I do that make a connection.	clients without disabilities. He discussed the need to build a bridge and make the connection, again saying if there was no connection therapy doesn't work. He described finding the point at which to make the connection.	
175-178	***Yeah. No, it absolutely. I mean that's the whole, the whole therapeutic process, right. Yeah. Getting that connection and that to me is the fun part of therapy is, is you know, people, you know, parents are bringing the kid in, my kids a mess, you got all them out and I'm just like let's connect first.***	P1 described the most important part of therapeutic process from his perspective as creating the connection with the client. He described parents bringing in a child with the goal of behavior modification and focusing on making the connection first.	Joining P3 described the importance of making a connection and finding a way to engage the client as being the most important part of the therapeutic process. He described needing to back up with caregivers at times who are looking for behavioral solutions and create the connection first.
178-180	***You know, we're like an ABA is like, you know, oh, this is the behavior, and we need to do these things to stop the behavior. It's like what's the whole thing of behaviors? Communication.***	He also addressed ABA therapy and the focus on behavior and stopping undesirable behaviors. He ended with stating the purpose of behavior is communication.	Judging P3 states his unfavorable opinion of ABA therapy and likens it breaking down communication as, in his opinion, behavior is communication.
184-188	***And I think sometimes the people with disabilities, the only way that they're going to communicate is with that behavior. And to and, and then it's, it's just having the patience to do it. I mean, I started my career working in a group home with people with intellectual disabilities with behavioral issues.***	P1 explained that at times people with disabilities only communicate with their behavior and that it required patience when working with them. He described his career as starting when he worked in a group home with people with intellectual disabilities and behavioral issues.	Competence P1 explained that, at times, the only way people have to communicate is with their behavior. He said that takes patience when working with the population, indicating his regard for them.
188-191	***I had to learn how to be present with them because I was entering [pause] I was looking at it as I was***	He described needing to learn how to enter their world and be present with them. He had difficulty articulating the perspective he had	Joining P1 described how he conceptualizes needing to

	entering their world. Yeah. I wasn't there to make their life, you know? I wasn't the I don't know what you want to call it, but I'm like, I was a privilege for me to enter their world. This is their home. I needed to treat it as such.	of his role at that time but described being respectful of their home. He spoke of home as being both physical and metaphorical. He described it a privilege to be able to enter their world.	learn how to enter a client's world or home both physically and metaphorically.
195-196	***When I started, I was direct care. So, changing diapers, bathing, teaching skills. All that fun stuff.***	P1 described his earliest work as being in direct care and responsible for the personal care needs of clients such as changing, toileting, bathing, and skill development.	
200-202	***It's no problem. You know, I wouldn't be and, and I say this all the time, I wouldn't be able to do what I do now without starting my career off working with people with disabilities.***	P1 explained how he often says that he would not be able to do what he does now as a therapist if it wasn't for his early work with people with disabilities.	Regard P1 ascribed value to his early work with disability in forming his competence as a counselor.
202-203	***Like learning to do life with people you know, prepared me to be a counselor more than going to grad school.***	He credited his ability as a counselor with experiencing life with people with disabilities more so than attending graduate school.	Policy P1 acknowledged the limitations of graduate school in forming his disability competence.

Appendix K: Participant Follow-up Interview Example

[redacted]

So you guys all ready for Christmas?

As ready as we're gonna be.

So I have just a couple of, of follow-up questions from the first time. So when we were, when you were telling me about your first client, the one who's the businessman? Who has the business, okay, and what it's like to be in session with him? And with him, you said that it really did kind of feel like traditional therapy despite the disability. So what about working with him really does make it feel like it's more traditional therapy?

Because it is, it is, I guess I'm using it more like cognitive behavioral therapy with him. You know, thoughts, feelings, beliefs and that whole cycle. And you know, he, he's created a worldview that the world looks like this, and then he flows from that and then to try to get him to change. Because what his the system he created isn't working. And he's like, "I don't understand". Like, well, what's really cool is I had his wife in two weeks ago. And, um, just talking to about communication. And both of them were like, "Wow, I didn't realize that. You know, I didn't know that. I thought you knew that." And so it opened up all these things by just, you know, teaching, translating. You know, I guess I translate autism to other people well.

OK. So for the ones who are more limited and it's and it's not like traditional therapy, what's going through your head? When you're having to adapt stuff in those sessions.

I, I'm finding a way to, I have to find a way to connect with the individual. I gotta, I gotta, they gotta let me into their world. So I'm looking to find a way to build a bridge.

So was there this thought process that's going on through your head at that point?

Yeah, I mean it's, it's, it's where can I, where are they going to give me access? And, and once I get the access then everything else starts to open up and flow from there. Same thing like the, the, the guy who has the business. He relates so well to computers that I, I translate, you know, life and people and communication into a, you know, a computer analogy. And then he just gets it and, and it was [pause] so it's like, you know, he doesn't want to change. You know, because he's created a system in a worldview that works for him. Like, "That's great, but you know when, when you bought your computer it came as it is, but have you made changes and upgrades? Yeah, okay so it's not the same as the original thing?" " No, of course not. I got to do this. I gotta do that. I gotta do, I gotta set it up the way I want." "Ohh, but then a new program you want requires you to [pause]" And one of the things he was having trouble letting go of stuff. And I was like, "Well, in your computer, if you never defrag and clean out your system, what happens? What? It slows down and then your computer doesn't work so well, right?" And then you see the light bulb come on in his head and that's the really cool, you know? So, but yeah, in the same way that's a lot like normal therapy is where you're,

you're drawing somebody in and you know getting them to realize, you know, things they didn't realize. But then when they get it, you know, it's super cool. Yeah, so you're just doing this in a different way, yeah, and the connection may be a little harder to find and a little harder to get to. I was working with somebody over the summer and, you know, we, he wouldn't talk to me much, but then we started playing chess. And then we use chess as the metaphor to, to for me to get in and then he would talk to me about yeah, it's hard for him to, understand people and situations really well. Then it's, "You gotta play it like the game of chess is. You gotta understand how things move, and once you understand how things move, then you can build a plan on how you're going to deal with it." Aye.

Um, and my last question goes back to your sister. Because you talked about, you know, even though she has Down Syndrome, even though she has an intellectual disability, that you were not just gonna let her get away with something. Do you ever find yourself doing that in sessions where you're, just because the client has an intellectual disability, that you're not going to let them just have a pass or get away with something?

Oh, yeah. Well, because people are coming to me for a reason and if they're they want to blame their disability for it I'm like, "That's not how it works. It's not how it works."

Um, can you think of any very specific examples of of when something like that happened?

Well, I mean, even like the, like autism, you know, they'll say, "Oh, well, I can't do that because I have blank" "Where's that in the book?" Okay you know and, and like people tell me that like all the time. Like with ADHD, "Ohh, I can't do that because I have this or that." I'm like, "No. You can learn about yourself, you can learn how your brain works, and then you can work to create systems to deal with yourself. So like, now, because anything can change. If you do the work, yeah, you might always struggle at something. You might not be great at it, but it you know what? It's the old Henry Ford quote. If you think you can, you think you can't. You're right." I mean that's, that's been my, my whole career and like the, the place, the place where I started my career is called Avenues to Independence, and their, their tagline was "putting aside old ideas about what was possible". You know, so, then I started with people in a group home with it, and if they wanted to try something or wanted to do something, it's like, "Alright, let's figure out a way to make it happen." You know, and then you do it. And no, some of those things didn't work. I don't know. I, I can tell. [pause] I don't know if I told you the story, but this is um, one of my guys with Down Syndrome. And. He, he wanted to he's like, "I want a job." He was in the sheltered work center and so we worked and we found him a job and what was cool is this job got out, like, close to the time where it was going to be more difficult for him to go back to the shelter workshop and then get in the, you know, get a ride home. And he lived in his home that he grew up in. His parents donated it when they passed away. And, um, we're like, well, why can't he? And he was like, "Why can't I just go home instead of having to go here and, and then get a ride back?" And I'm like, "Yeah, let's figure that out." And we figured it out and, and so one day that after we had figured this out, I, I swung by the house and he was there and he's like, "I'm independent." I'm like, "What do you mean?" And you know, he's like, "I get to go, I go to my job and I get to come home and I, I get to be by myself, I, I'm independent." But like the smile on his face, you know, was like, yeah.

So it certainly sounds like your sister and memories like that kind of shaped how you then approach clients today.

Absolutely. Because I I've seen so many people that were told all their life that they couldn't do it. And they did it.

Does it ever? Does the reaction from a client ever surprise you because all of a sudden, potentially, they're faced with someone for the first time who isn't just going to let the disability be the pass?

Yeah, I mean and it's a growing thing and you know, I, I equate it to like a muscle. The more you work it out, the stronger it gets, Okay. And, and that was the whole thing like 20 years ago the whole, you know, self-empowerment and disability community, you know, "I know my rights." "Okay, yeah, you have rights, but let's play this out. Do you understand what your rights mean?" And then we kind of know it and kind of not. Um, but it it just creates that attitude of anything can happen if you work at it.

Yeah, I can just imagine someone who's kind of been placated through their disability most of their life all of a sudden sits face to face with you and is kind of held accountable to their own actions it being a surprise.

Yeah, well, that's, I mean, people with personality disorders don't tend to stick with me very long because I'm always asking them to you know. [pause] "Okay, what are you gonna do differently this week?" Okay, "I just want to come in and complain." "That's not really what I'm here for. I can do that a little bit, but."

So, and I think there's some special, especially because you had so much exposure and experience, people with disabilities throughout your life, throughout your career. Kind of the same thing for me. And so, like, "Yeah, so you use the wheelchair? Cool. That doesn't mean you're sitting on the sidelines let's, you know, figure it out. And they're like, "Wait, what? No one's ever made me, no one's ever made me figure this out before."

Yeah. "Where do you want this wheelchair to take you? I mean, I can go places."

Absolutely. And I think that. That's where we need to get disability competence too, yeah.

Totally.

But those are all the questions that I had.

OK. Thank you very, very much, um, for what you're doing, because, I mean, the goal would be to, to be able to do something with it to help more people.

Absolutely. Yeah, absolutely. Well, have a great day.

I'll talk to you later. Alright, take care. Bye-by