

**DISABILITY AND SEXUALITY:
A MANUAL FOR COUNSELLORS**

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Abstract

People who have disabilities are typically given little guidance or support around sexuality or sexual health, due to pervasive cultural myths and stereotypes that suggest people with disabilities are not viable sexual beings. This lack of exploration around sexuality has negative impacts on quality of life, and is correlated with increased risk for sexually transmitted infections, unplanned pregnancy, inappropriate sexual behaviour, vulnerability to sexual exploitation or assault, and emotional concerns such as low self-esteem. An ever-growing body of research has shown that people with disabilities benefit from exploring their sexuality in a healthy way and experiencing safe, fulfilling sexual relationships. Counsellors are in a unique position to explore sexuality-related concerns with clients who have disabilities, thereby challenging cultural stereotypes and increasing well-being of clients. This project incorporates literature on sexuality and disability into a manual for counsellors who wish to increase their competence in working with clients who have disabilities, as well as in approaching sexuality-related issues with these clients.

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Chapter 1: Introduction to Research

An ever-growing body of research has shown that people with disabilities benefit from exploring their sexuality in a healthy way and experiencing safe, fulfilling sexual relationships. However, sexually-related issues are often ignored in the work that is done with people who have disabilities as a result of prejudicial myths about disability and sexuality. Failing to explore sexuality and sex-related concerns can contribute to negative impacts on clients' wellbeing, including increased risk of sexually transmitted diseases or unplanned pregnancy, vulnerability to sexual assault and exploitation, shame and poor self-esteem, inappropriate sexual behaviour, and diminished rapport with the counsellor (Milligan & Neufeldt, 2001; Rousso, 1993). In this final project, I aim to provide a manual for counsellors to develop competence and comfort in exploring sexuality-related issues with clients who have disabilities. I also aim to challenge myths and negative attitudes, provide insight into the unique experiences of many clients with disabilities, and highlight ethical implications of exploring sexuality with clients who have disabilities.

This final project serves to consolidate research regarding sexuality and disability into a manual for counsellors. For the remainder of this chapter, I will present the rationale for why this project is a necessary addition to the knowledge base of counsellors, provide a description of the context in which this research was completed, and provide an overview of the project.

Rationale

This final project aims to help counsellors develop competence to explore sexuality with clients who have disabilities. Ethical practice dictates that counsellors

should have competence in working with particular issues or populations, should seek professional development to increase their competence, and should provide services that will benefit the client, while avoiding harm to clients (Canadian Psychological Association, 2000; CPA). Although research has provided clear evidence that people with disabilities benefit from exploring their sexuality and are at risk of harm if they have limited knowledge around sexuality, training opportunities for counsellors on this topic are very limited. Counsellors are likely to work with clients with a disability of some kind in the course of their careers, and due to the nature of this relationship, sexuality-related issues are likely to arise within the counselling session. Therefore, it is crucial for counsellors to have sufficient training in working with clients with disabilities, as well as a solid understanding of sexuality-related issue and strategies for working through these issues.

Despite disability prevalence rates of 13.9% in Canada (Statistics Canada, 2013), relatively little research has been done that outlines the unique counselling needs of clients with disabilities; this knowledge is crucial for providing clients with disabilities effective counselling (Kanellakis, 2010). Even less training provides information regarding sexuality-related concerns that may arise within the counselling setting (Foley-Nicpon & Lee, 2012; Hough & Squires, 2012; Weiss, Lunskey, & Morin, 2010). Specific training regarding the issues and concerns that affect people with disabilities is a necessary addition to general counsellor education, because this training will minimize potential risks and maximize benefits to clients, as well as enable counsellors to reflect upon their current attitudes and stigmatized beliefs. Currently, very few counsellors regularly work with clients who have disabilities. As a result, many people with

disabilities are left without necessary support to explore important issues. Counsellors who are confident and able to work with people with disabilities are not necessarily able to effectively work with clients who have sexuality-related concerns, as the issues that affect them are complex and often intertwined with greater political issues.

In much of the world, people with disabilities are isolated, segregated, and subject to discrimination due to their disability, in the form of overt violence and discrimination or the denial of rights and freedoms (Ali, Hassiotis, Strydom, & King, 2012).

Dependence on others influences the lack of sexual exploration of people with disabilities, especially considering that there is a belief that individuals with disabilities may show aggression or be particularly vulnerable to abuse, which dissuades family members and service providers from facilitating sexual exploration (DeLoach, 1994; McCabe, 1993). People with disabilities often experience stigmatization in the pursuit of intimate relationships, and are limited by prejudicial beliefs, negative views of their attractiveness or viability as partners, and a belief that people with disabilities are asexual (McKown, 1986; Milligan & Neufeldt, 2001). These discriminatory beliefs are often internalized by people with disabilities, leading to negative effects on emotional wellbeing, including loneliness, social isolation, shame, and guilt.

People with disabilities benefit from exploring issues related to their sexuality in a safe, nonjudgmental counselling space (Porat, Heruti, Navon-Porat, & Hardoff, 2012). Although the field of research in this area is rapidly growing, work is typically focused on clients who are in distress (Milligan & Neufeldt, 2001), as opposed to exploring sexuality as a normal part of psychosocial work. Exploring sexuality with people who have disabilities can lead to growth in independence (DiGiulio, 2003), overall quality of

life, and self-esteem (Taleporos & McCabe, 2002). Counselling in this area also serves to reduce risks to people with disabilities on a variety of levels. Knowledge around sexuality and safe sexual decisions reduces risks of unplanned pregnancy, sexually transmitted infection, and sexual victimization. Counselling that explores sexuality also reduces the negative impact of shame, guilt, and poor self-esteem. Finally, counselling can contribute to a reduction in inappropriate or aggressive sexual behavior.

Given that the importance of the attitudes of counsellors in the quality of service provided to clients with disabilities, it is necessary to understand counsellor attitudes regarding sexuality and disability and what factors influence these attitudes. Training has long-term benefits on counsellor knowledge and attitudes around clients with disabilities' sexuality. Training also allows counsellors to develop the skills necessary to comfortably broach this subject with clients (Fronek, Kendall, Booth, Eugarde, & Geraghty, 2011). This manual will contribute to the resources of counsellors working with this population, as well as in their work surrounding issues of sexuality in general. Training counsellors to work with clients with disabilities is grounded in ethical practice. Hertzprung and Dobson (2000) argued that counsellors are ethically obligated to provide competent, multicultural service, and that educational programs are required to train counsellors to work with diverse populations. As counsellors, we are obligated to ensure that we do not unwittingly discriminate against clients and do no harm to clients (CPA, 2000). Hertzprung and Dobson noted that despite these ethical guidelines, training counsellors to act upon diversity-sensitive ethics is difficult, and most of the training in cultural diversity provided to counsellors is grounded in racial diversity.

CPA guidelines do not specify that psychologists are required to have training in working with clients who have disabilities. However, in other countries counsellors are required to develop competence in working with people who have disabilities. For example, clinical psychology students in Britain must have six months' worth of training in issues affecting those with developmental disability (British Psychological Society, 2005). With the ongoing movement from institutionalization to community-based services, counsellors will work with people who have disabilities far more frequently, and it is imperative that competence is established (Weiss, Lunskey, & Morin, 2010).

Research Context

All researchers enter a project with a set of assumptions and biases about the research question, and fully separating the researcher's views from their understanding of their work is not possible (Wong-Wylie, 2006). Therefore, it is necessary to present the context in which this project was completed. As a researcher, I am a collaborator with all researchers who have provided information that I draw from (Emerson & Frosh, 2004). I have interpreted data through my lens as a beginning counsellor, an advocate for people with disabilities, and as a person who has been involved in sexuality-related research. My viewpoint of sexuality is that it is an important aspect of a person's overall life, and that it is the responsibility of families, communities, and people in helping roles to explore this issue and assist people in developing healthy, enjoyable sexual lives. It is important to note that I subscribe to the belief that all people have some kind of sexual life, and that all people engage in some sort of sexual behaviour (e.g., fantasizing, masturbating, engaging in sexual acts with partners). As a counselling student who also works in the disability services sector, I bring both my understanding of supporting

people with disabilities, as well as my personal theory of change and my understanding of the goals of counselling to this project. I approach my understanding of developmental disabilities from a constructivist viewpoint, although I would suggest that the biological factors present in many disabilities play a substantial role in the barriers and particular strengths of clients.

Much of the personal experience I have in working with people who have disabilities has been within the Albertan disability service sector. As a result, I have engaged with people who have lived in a range of conditions, who are from richly diverse backgrounds, and who receive the majority of their supports from government-funded programs. Typically, these programs utilize daily support staff that assist clients with areas that they require help, home support staff who assist clients with daily living activities, and specialized supports including medical professionals who meet other needs of clients. Currently, the Alberta government agency that funds disability supports, Persons with Developmental Disabilities, measures outcomes and support needs using the quality of life framework (Brown, Schalock, & Brown, 2009; Schalock, Alonso, & Braddock, 2002). The quality of life framework breaks overall quality of life down in to several broader categories of health and wellbeing, with specific outcomes related to each category. It is now the responsibility of professionals, including counsellors, to work towards developing quality of life for clients.

Providing counselling to a client with a disability who receives these supports requires collaboration with a team of people, all of whom have different goals, different educational backgrounds, and have varying daily experiences with their clients. Counselling this population also requires collaboration with families and guardians who

have an altogether different understanding of the needs of their loved one. It is important to understand that counsellors must focus first on the needs of their clients and their ethical obligations, while paying special attention to the dynamics that exist around their clients in the form of their other supports. The research that has been compiled in this project has been applied to a disability service system that is similar to that of Alberta's. It is necessary to note that this system is not necessarily universal, and so the understanding of disability and sexuality that I present in this project may not be applicable for counsellors working in other systems. Still, an effort has been made to gain a cross-cultural understanding of disability and sexuality throughout my research.

Overview of Project

In this final project, I present a manual for counsellors to explore sexuality when working with clients who have disabilities. The manual was developed based on the information gleaned from a comprehensive literature review of the current literature, which is presented in Chapter 2. Specific methodology for the literature review and development of the manual is reviewed in Chapter 3. In Chapter 4, I present the manual, which weaves the experiential information of people with disabilities with the research on effective counselling for clients with disabilities, and attempts to encourage self-reflection of counsellors on their personal biases and assumptions, as well as to highlight some of the major issues that people with disabilities face regarding their sexuality, and to provide some strategies for working with this population in a counselling setting. Finally, in Chapter 5 I explore areas of future research that would benefit counsellors, as well as reflect on my personal growth and experiences in completing this project.

Chapter 2: Literature Review

As an important component of overall wellbeing, sexuality is a topic that is commonly discussed in a counselling setting. An ever-growing body of research has shown that people with disabilities benefit from exploring sexuality in a healthy way and experiencing safe, fulfilling sexual relationships. However, due to stigma and the attitudes of people who provide support to individuals with disabilities, sexuality-related issues are often ignored. Alarming, failing to explore sexuality and sex-related concerns can have negative impacts clients' wellbeing and can increase risks associated with unhealthy sexual activity. Given that clients themselves have limited knowledge around sexuality, particularly in the areas of sexual health, it is dangerous to avoid these conversations in all support settings, including counselling (Leutrar & Mihokovic, 2007). However, the attitudes of client's support systems, including counsellors, impact whether these conversations occur, and how sexuality-related issues are discussed in counselling (Aunos & Feldman, 2002; Wolfe, 1997). More education and experience with people who have disabilities leads to changing attitudes that reflect an ideology grounded in inclusion, quality of life, and independence. In this chapter, I will review the current literature regarding counselling clients with disabilities, particularly as it pertains to sexuality concerns. The following sections will explore historical factors that have influenced disability and sexuality, specific challenges that those with disabilities face regarding their sexuality, and the role of counsellors in the support of individuals with disabilities.

Working Definitions

Much of the literature regarding disability, counselling, and sexuality uses different terminology to describe populations and behaviour. The research that I will summarize here has explored a variety of forms of disability, and each article views disability through a slightly different lens. Terminology varies internationally, and is ever-changing due to significant progress in advocacy for people with disabilities. As such, it is necessary to provide working definitions for the terms used throughout this chapter.

Disability is a word with a variety of connotations and definitions. The World Health Organization (WHO, 2002) recognizes that *disability* encompasses physical impairments, limitations in executing tasks or engaging in activities, and restrictions in involvement in life experiences. WHO recognizes that “disability is thus not just a health problem [but] it is a complex phenomenon, reflecting the interaction between features of a person’s body and features of the society in which he or she lives” (para. 2). WHO has propelled a worldwide movement to shift the focus away from limitations of those with diagnosed disabilities to the overall level of health of an individual. In fact, WHO (2002) “acknowledges that every human being can experience a decrement in health and thereby experience some disability” (p. 3).

Although WHO has attempted to synthesize working definitions of varying kinds of disability into one overall definition of *disability*, most of the body of research on sexuality and disability distinguishes between primarily physical disabilities and primarily cognitive disabilities. *Physical disability* is generally defined as limitations in functioning of the body or parts of the body (WHO, 2002), whereas cognitive disabilities

(*developmental disability* or *intellectual disability*) is defined as limitations in intellectual capacity and adaptive skills.

Much of the research that will be reviewed in this section focused on physical disabilities, typically with respect to specific concerns, such as spinal cord injury. Given that disability has historically been viewed through the lens of physical impairment (Parchomiuk, 2013), it is unsurprising that the basis of research on sexuality and disability has been rich in research that focused on how physical impairments affect sexual functioning. Consequently, the body of work that examines the sexuality of individuals with cognitive disabilities is relatively unexplored. Throughout this paper, I will use the term *disability* to encompass physical, adaptive, and cognitive limitations, recognizing that disability is a multifaceted experience.

Sexuality is also an umbrella term that encompasses physical, psychological, and social experiences. WHO (2002, as cited in Edwards & Coleman, 2004) defines *sexual health* as “a state of physical, emotional, mental and social well-being related to sexuality” (p. 190). In line with this understanding of sexual health, *sexuality* can then be defined as the physical, psychological, and social experiences of sex, including the sexual body, sexual activities, sexual orientation, sexual identity, and social roles related to sexuality.

The Canadian Context

The history of disability is complex and unclear, due to the common exclusion of the stories and experiences of people with disabilities in our recorded history (Gleeson, 1997). However, understanding this history is necessary for counsellors who aim to work with clients with disabilities from a culturally-sensitive lens. Throughout history

individuals with disabilities, particularly those that had visible disabilities, were considered less favourable, or even less human, than those without disabilities. Due to the pervasive discriminatory beliefs about individuals with disabilities, much of the history that is available has been written from the perspective of clinicians and institutions that treated people with disabilities, rather than from the experiential perspective of those with disabilities themselves (Bredberg, 1999). This history continues to impact how our society views disability, and therefore influences the policies and practices we use to support individuals with disabilities. Our history also impacts the experiences of people living with disabilities even today. In this section, I will review the history of disability services in Canada, with a particular focus on Alberta history.

Attitudes about what constitutes disability and how that influences an individual's value as a person affect the lived experience of people with disabilities in a variety of ways: attitudes inform (1) the practices that we use in therapeutic and rehabilitation settings; (2) the political policies that we develop; and (3) the extent to which the community is involved in the support of people with disabilities, through direct action or through support for political policies. There has been a substantial change over time in attitudes about what constitutes a disability, effective intervention strategies, and the ethical concerns that impact the work that is done with people who have disabilities. For a large portion of Albertan history, individuals with disabilities were seen primarily through the lens of their limitations, and largely considered unfit to live in communities with people who were considered non-disabled. Until 1972, people with disabilities were being sterilized under the Sexual Sterilization Act of Alberta, and institutionalization of

people with disabilities was common well into the 1980s (Grekul, Krahn, & Odynak, 2004). Institutions such as Michener Center (also known as the Provincial Training School for Mental Defectives) in Red Deer, Alberta housed individuals with disabilities in reportedly inhumane conditions, typically with limited freedoms.

In my personal conversations with individuals who lived at Michener Centre well into the 1990s, I have been enlightened about the severely oppressive living conditions, and how these experiences have lifelong effects on the well-being of clients who resided in institutions. For example, a client that I worked with shared her memories of being segregated from men who lived in Michener Centre, spending many hours of her day staring out of large windows, or completing projects (e.g., craftwork) that were then sold by Michener Centre as a means to increase funding. She would only see her family once- or twice-a-year because clinicians advised that visitations would be disruptive to her life, as well as emotionally damaging to her family. Most disturbing was her description of life at Michener Centre as a mix between a prison and a psychiatric hospital.

Within Alberta history, sterilization was used as a way to prevent people with disabilities from becoming parents, under the belief that their children would be born with disabilities (Grekul, Krahn, & Odynak, 2004). This practice highlights the attitudes about disability that were held by the general public. Sterilization was seen as a necessary measure to prevent individuals with disabilities from having children, and these actions were justified by a popular belief in the framework of eugenics. Eugenicists argue that the genetic quality of the human race can be improved through the promotion of reproduction by those with desirable traits, and the limiting of reproduction by those with less-desirable or undesirable traits (Hawkins, 1997). The eugenics ideology, based on

Darwinian principles of selection, proposed that healthy living and social purity could be achieved only through ensuring that people with “undesirable” traits were not permitted to have children (McLaren, 1990). Unsurprisingly, the belief that those with disabilities were undesirable due to the perceived limitation in their abilities was widespread during an era in which eugenics informed social policies in Europe and North America. It was believed that a person with a disability would necessarily have a child with a disability, and this outcome was considered unwelcome.

In Canada, the only two provinces to legislate the use of involuntary sterilization of people with disabilities and other undesirable qualities were Alberta and British Columbia (Grekul, Krahn, & Odynak, 2004), and the sterilization and segregation of individuals with disabilities occurred widely throughout the United States in the 1920s and 1930s. Leilani Muir, an Albertan-born woman who lived at Michener Centre, famously filed, and won, the first lawsuit against the Government of Alberta in 1995 for her sterilization under the Sexual Sterilization Act of Alberta (Grekul, Krahn, & Odynak, 2004). This important turning point spurred several class action lawsuits against the provincial government, with approximately 850 Albertans being awarded damages, and the Alberta government issuing a public apology to the almost 3000 people who were sterilized under the Act. Since the 1980s, there has been a push towards inclusion and community living in Alberta.

The first waves of movement away from institutional settings brought individuals with disabilities into group home settings, where several people with disabilities were placed together in a home and supervised by support workers at all times (Government of Alberta, 2010, p. 3). People with disabilities began to enter the public education system,

albeit typically in segregated classes. More recently, the focus of agencies that support people with disabilities has been on inclusion in classrooms, workplaces, and communities, as well as the promotion of independence, inclusion, and quality of life. In Alberta, people with disabilities often attend structured programs during the day with other people who have disabilities, and often live with supportive roommates, family, or independently. Agencies that provide support to people with disabilities are funded through the provincial government, and are tasked with providing appropriate services for clients. Although there has been a great deal of progress from the institutionalization characteristic of the early 20th century towards community inclusion, the attitudes that perpetuated the segregation and discrimination of people with disabilities persist today. These attitudes continue to limit the opportunities of people with disabilities in virtually every area of life (e.g., social relationships, employment, education, and access to professional services). Germane to this paper, attitudes regarding disability and the limitations associated with disability continue to limit access to sexual partners, sexual education, and competent counsellors who can broach these concerns.

Conceptualization of Disability

Several major models seek to conceptualize disability, including the causes of disability, the resulting outcomes, and the kind of treatment or support that is most effective (Parchomiuk, 2013). Although only a select few models will be explored in this project, a variety of models that seek to explain what disability is and how disability occurs have been proposed. For much of human history, disability was recognized as illness or deformity that was socially and personally undesirable. Parsons (1951) proposed a functional understanding of disability in which disability constitutes a social

role that has specific expectations and limitations, and those that have disabilities are exempt from the responsibilities of membership in social life. This understanding of disability is grounded in the medical model, which focuses on biological differences between people with and without disability, and posits that disability is caused by biological defects that lead to limitations in functioning. From the medical model perspective, support is intended to manage limitations and treat primarily physical concerns. From the perspective of this model, sexuality is viewed through a biological lens only, and the focus is on impairments of sexual functioning and sexual organs. A proponent of the medical model is likely to primarily explore an individual's ability to engage in sexual intercourse and effective parenting. Over centuries, the focus on biological sexual functioning has stimulated the attitude that people with disabilities cannot have sexual intercourse, and therefore do not have sexual needs.

Although a biological understanding of the causes of disability is necessary for the treatment of some of the concerns that arise as a result of disability, the medical model has been criticized based on several limitations (Parchomiuk, 2013). First, the medical model implies that the primary causes of disability are within the individual (e.g., biological), without recognition for cultural or social impacts on disability (Oliver, 1996). Second, the medical model perpetuates the labelling of people with disabilities in ways that ignore the personal experience and abilities of the individual (Barnes, 1991). Third, the medical model does not lead to the incorporation of personal experience, cultural diversity, or psychological functioning into treatment or support plans. Finally, the medical model has been criticized for perpetuating negative attitudes regarding disability,

most commonly that people with disabilities deviate from “normal” functioning and that people with disabilities are “abnormal” (Scullian, 1999, 2010).

An alternative model that seeks to address the limitations of the medical model is the social constructionist model. This model was originally developed by the Union of the Physically Impaired Against Segregation in the 1970s (Anastasiou & Kauffman, 2011), and suggests that society creates a negative social identity for people with disabilities, thereby granting the population without disabilities the ability to exclude those with disabilities. The social constructionist model posits that as a result of this exclusion, the contributions of people with disabilities are undervalued, and society has actually manufactured disability by failing to address constraints that would enable greater inclusion for individuals with disabilities and access to resources. In stark contrast to the medical model, the social constructionist model focuses on personal experience and external perceptions of ability, rather than on limitations or personal weakness. Although the social constructionist model has received support in academic circles, this approach is not as commonly used in the organizations that support people with disabilities, nor has it fully entrenched social understanding of disability. Related to sexuality and disability, the social constructionist model proposes a holistic view, in which sexuality and disability is normalized, and the physiological and psychological aspects of sexuality are recognized (Parchomiuk, 2013).

Several limitations of the social constructionist model have also been proposed, the most common of which is that the social constructionist model relies heavily on anecdotal evidence and personal experience, to the exclusion of the scientific method (Anastasiou & Kauffman, 2011). Due to the perceived lack of scientific rigor, social

constructionist research is seen as falsely attributing personal experience to public attitude, therefore representing an unbalanced model (Shakespeare, 2000). Additionally, the social constructionist model has been criticized for an over-zealous pursuit of inclusion, which is argued to inhibit effective, realistic treatment options and support for people with disabilities.

The social minority model of disability recognizes that the discrimination that people who have disabilities face is the result of stigmatizing attitudes, and disability itself is defined as the result of interactions between individuals and their environment (Hahn, 1996). People who have disabilities suffer negative effects that are not the product of medical conditions, but the result of social neglect and consistent and systematic discrimination (Bickenbach, Chatterji, Bradley, & Ustun, 1999). People with disabilities are not broken individuals that need fixing; rather, they are people whose human rights have been violated (Barnes, 1991; Silvers, 1994). Therefore, this model is intertwined with political activism for the rights of people with disabilities, with an aim to fully encapsulate disability issues in social policies and ensure political representation for the rights and needs of people with disabilities (Bickenbach et al., 1999).

The World Health Organization (WHO) argued that neither the medical model nor social models fully recognizes the complexity that disability plays in a person's life, nor the role and impact of internal and external factors. To this end, WHO has proposed a biopsychosocial model of disability, and synthesizes this understanding of disability in its *International Classification of Functioning* (ICF; WHO, 2002). ICF encompasses health conditions, such as diseases, disorders, and injuries, as well as contextual factors that influence disability. Contextual factors can be broken down in to environmental

factors (e.g., social attitudes, legal structures, and terrain or climate conditions) and personal factors (e.g., gender, age, social background, personality, current experience). Taken together, ICF considers functioning within the body, the entire person (e.g., personal experience, psychological factors, personality), and the social context in which that person lives. Factors that impact disability and sexuality will be viewed through a similarly wide lens, and consideration will be made for both biological and personal factors that impact the sexual experience of those with disabilities.

Quality of Life

The quality of life framework is a natural fit with the WHO conceptualization of disability. Quality of life (Schalock et al., 2002) is a concept that has attracted a lot of attention by both researchers and government bodies that fund supports for individuals with disabilities due to its incorporation of political, cultural, physical, social, and psychological aspects in a model of health. The quality of life paradigm suggests that functioning can be broken down into three main indicators of wellness and their sub-domains that are considered necessary to achieve health: (1) well-being is subdivided into emotional, material, and physical well-being; (2) independence is subdivided into personal development and self-determination; and (3) social participation is subdivided into the domains of interpersonal relations, social inclusion, human rights, and legal rights (Schalock et al., 2002). The quality of life framework is commonly used by organizations that support individuals with disabilities across the world. In Canada, provincial government agencies have begun utilizing this framework as a baseline for determining necessary services and distributing funding.

The quality of life framework is a useful tool for exploring the myriad of factors that impact the health and wellness of people with and without disabilities. For the purpose of this project, sexuality can be considered from within a quality of life framework in order to elucidate the importance of continued research, training, and discourse about sexuality and disability. Sexuality can arguably relate to emotional and physical well-being, in which sexual activity may increase both emotional and physical well-being, and limitations in emotional and physical well-being may limit access to sexual experiences. The freedom to make choices about sexual activities and partners is a factor of independence that is often not enjoyed by people with disabilities, particularly those with legal guardians in their adult lives. Finally, sexual expression and exploration has an impact on social participation, while limitations in opportunities for social participation necessarily impact sexual opportunity and sexual expression. Given the work of WHO in dispelling worldwide misconceptions about disability, it can be argued that sexuality is a human and legal right, and that a lack of willingness to explore and approach sexuality and disability is a violation of these rights. A good quality of life for people with disabilities must necessarily incorporate opportunities for the exploration of sexuality, a task that involves the network of support professionals that provide services to people with disabilities. Arguably, counsellors hold a unique and necessary role in facilitating increasing quality of life through the exploration of sexuality.

Attitudes Regarding Disability

As noted previously, disability is a socially applied label and represents societal attitudes of disability. Although changing public policy suggests that societal attitudes toward disability are becoming more liberal and inclusive, stigma and discrimination

towards people with disabilities is still rampant. Public understanding of disability is still wrought with stereotypes that limit inclusion, access to resources, and independence of individuals with disabilities (Livneh, 1984; Scior, 2011). Scior extensively overviewed the general attitudes and stereotypes regarding people with disabilities, and overwhelmingly showed that these attitudes do not favour community inclusion. Rather, attitudes about disability encourage the blockage of community inclusion for people with disability, and negative attitudes about disability can lead to increased vulnerability to abuse, coercion, isolation, and poverty, as well as limited access to resources (Ali et al., 2012). Negative attitudes impact the experiences of people with disabilities in harmful ways, ranging from actions such as the denial of basic rights and freedoms to overt acts of violence and discrimination. Additionally, public attitudes impact individuals' access to employment, the kind of medical care they receive, and inclusion in educational programs (Holmes, & McWilliams, 1981; Merkens, Perrin, Perrin, & Gerrity, 1989; Tervo, Palmer, & Redinius, 2004)

Subtle forms of stigmatization are often unacknowledged or perpetuated by those who provide support to people with disabilities, especially those actions that are situated in attitudes that have been ingrained in culture and public policy. For example, if a person with a disability asks his support worker a question regarding sexuality, and that question is ignored due to the support worker's perception of sexuality as excluding people with disabilities, that person is being stigmatized. The message that is sent to the person with a disability could range from a message that sexuality is not a safe topic to discuss with those providing support, that sexuality is not a topic that can be addressed, that sexuality or sexual expression is wrong, or that the sexuality of this person in

particular is wrong. Aunos and Feldman (2002) reported that people with disabilities had conservative attitudes regarding sexuality, and their families often supported sterilization methods for those with severe disabilities. Stigmatization of those with disabilities perpetuates false beliefs about sexuality and disability, and these beliefs can be harmful to the well-being of people with disabilities.

Interestingly, given more education and experience with people with disabilities, attitudes tend to change to reflect a greater understanding of the importance of inclusion. Given the growing understanding that inclusion should be a primary goal in supporting clients with disabilities, it is necessary that all professionals reflect on their attitudes and beliefs about clients with developmental disabilities. Germane to this project, counsellors must be prepared to recognize and work through the effects of stigmatization that people with disabilities encounter, and counsellors must be willing to advocate for the rights and well-being of people with disabilities (Ali et al., 2012).

Attitudes regarding sexuality and disability. One of the major challenges faced by people with disabilities is stigma and negative attitudes around their value as sexual individuals (DeLoach, 1994). People with disabilities often experience stigmatization regarding their ability to engage in sexual and intimate relationships; access to sexual and intimate relationships are limited by prejudicial beliefs, negative views of the attractiveness or viability of people with disabilities as partners, and a belief that people with disabilities are asexual (McKown, 1986; Milligan & Neufeldt, 2001).

Milligan and Neufeldt (2001) provide a comprehensive review of the literature that addresses the false beliefs held by professionals regarding the sexuality of individuals with disabilities. This review reported that there is an overarching belief that

clients with disabilities are asexual (i.e., without an interest in sexual behaviour and without sexual attraction to others), and this belief appears to be related to a misconception that a physical disability equates to a lack of biological sexuality, while a cognitive disability is equated to a perpetual childlike state. The belief that people with disabilities are asexual is false; although physical and mental impairments alter social and physical functioning, they do not change the basic drives towards love, affection, and intimacy (Medlar, 1993; Nosek et al., 1996). As a result of perpetuated negative beliefs regarding sexuality and disability, people with disabilities have limited access to romantic partners and limited opportunity to explore sexuality. The consequence of these beliefs of asexuality is a self-fulfilling prophecy; Milligan and Neufeldt noted:

...it is very difficult for [people with disabilities] to avoid internalizing social values and attitudes, which devalue them and deny their sexual nature. In a self-fulfilling prophecy, actual and/or perceived rejection may lead some [people with disabilities] to retreat from intimacy and ergo, the adoption of a nonsexual lifestyle. The consequences of these beliefs can be dire; historically mass involuntary sterilization occurred as a result of this belief system, and this ideology continues to have support amongst some service providers working with people with disabilities. Personally, these pervasive attitudes regarding the sexuality of individuals with disabilities can create barriers in socialization, marital success, and negative self-concept. (p. 92)

The false beliefs that people with disabilities have poor sexual functioning, cannot have orgasms, do not desire love or sex, and are perpetually childlike (Medlar, 1993; Nosek et

al., 1996) are connected to the equally limiting beliefs that people with disabilities are not able to be suitable parents and that they would bear children with disabilities as well.

In addition to the myth of asexuality, a variety of equally harmful, stigmatizing beliefs continue to be perpetuated. Paradoxically, individuals with disabilities are often seen as overly sexual, with uncontrollable sexual urges and a tendency towards sexual aggression (DeLoach, 1994; McCabe, 1993; Parchomiuk, 2013). Proponents of this belief argue that sexual education will awaken dormant sexual urges that are difficult to control. This belief that people with disabilities are not able to be accountable for their sexual actions seems to be tied to assumed limitations in cognitive functioning. Despite fears that people with disabilities will have children who have disabilities if given opportunity to engage in sexual behaviour, a persistent stereotype is that people with disabilities should only marry other people with disabilities. This belief is arguably connected to a taboo against those without visible disabilities choosing a person with a visible disability as a romantic or sexual partner (Parchomiuk, 2013). In each of the highlighted examples, it is clear that sexuality and disability is a taboo topic, wrought with false beliefs and assumptions, and taboos act to perpetuate this belief by limiting interest in research aimed at enhancing sexuality for people with disabilities.

The stigmatization of people with disabilities as asexual is not only perpetuated by the general population, but also by the parents, support staff, and professionals that serve people with disabilities. Cuskelly and Bryde (2004) designed an instrument that assessed the attitudes of an Australian sample parents, support workers, and community members regarding the sexuality of people with disabilities in eight realms: sexual feelings; sex education; masturbation; personal relationships; sexual intercourse;

sterilization; marriage; and parenthood. It was reported that this instrument had good test-retest reliability and good internal consistency. It was reported that parents of people with disabilities and participants who were older than 60-years-old held the most limiting beliefs regarding sexuality and disability. Generally, this study also reported that the realm of sexuality that was considered most negative by participants was that of parenthood. Cuskelly and Bryde (2004) argued that this result is due to the impact that parenting behaviours have on both children and parents, suggesting that “noncoercive sexual behaviour affects only the individuals involved, whereas childrearing has wider implications” (p. 260). Although this study was limited in the scope of groups that were assessed for their attitudes towards disability, the results of this study suggest that many of the support people who work with people with disabilities hold negative attitudes about sexuality and disability.

Professional attitudes and education. A variety of professionals encounter individuals with disabilities in their work, including physicians, nurses, social workers, teachers, people who provide direct, daily support to people with disabilities, and counsellors. Considering the generally negative beliefs regarding sexuality and disability held by families, support workers, and the general public, it is clear that the attitudes of professionals who work with people with disabilities will impact the sexual lives of people with disabilities, as a result of professionals’ willingness to explore sexual issues and to support the pursuit of romantic relationships (Kanellakis, 2010). It follows that professionals, including counsellors, play a role in perpetuating false beliefs and negative attitudes about sexuality and disability. Increasing the knowledge of professionals who work with people with disabilities is an important factor in addressing widely held false

beliefs and the provision of support that is grounded in a deep understanding of the experience of disability (Abbott & Howarth, 2007)

Attitudes towards sexuality and disability are related to several personal factors of the professional, including: age (i.e., older professionals typically report more conservative attitudes; Brantlinger, 1983); religiosity (i.e., more conservative religious beliefs are correlated with more conservative attitudes about sexuality and disability; Almore & Weidner, 2002, as cited in Kazukauskas & Lam, 2010); the specific role of the professional in the support of a person with a disability (i.e., daily support workers hold more conservative attitudes than specialists that are visited infrequently); educational background (i.e., more education is correlated with less conservative attitudes about sexuality and disability; Brantlinger, 1983); and the specific training around sexuality and disability that the professional has completed (i.e., specialized training and more experience with direct support is correlated with more positive attitudes; Booth, Kendall, Fronck, Miller, & Geraghty, 2003; Murray & Minnes, 1994; Murray, MacDonald, & Minnes, 1995). Fronck and colleagues (2011) noted that training has long-term benefits on professional knowledge and attitudes around sexuality and disability, and enhances the development of skills that are necessary to comfortably broach this subject with clients. Effective work in supporting clients around their sexuality relies on non-judgmental environments in which professionals acknowledge and challenge bias and prejudice around sexuality (Lewis & Bor, 1994). Currently, practitioner perceptions of the sexuality of clients with disabilities contributes to a reluctance to discuss sexuality with clients (Guthrie, 1999), although this can also be affected by external conditions such as workload, lack of privacy, and lack of confidence with the subject matter. Although

Guthrie explored the work of nurses in particular, the issues that affect willingness to discuss sexuality concerns appear to cross professional boundaries (McKown, 1986; Milligan & Neufeldt, 2001).

Although the field of sexuality and disability research is rapidly growing, work is often focused on clients who are in distress (Milligan & Neufeldt, 2001), and research that explores sexuality as a normal part of psychosocial work is limited. In order to address false beliefs and unwitting discrimination against those with disabilities, professionals need to be exposed to careful training in sexuality and disability. Future research addressing sexuality and disability would serve both professionals and people with disabilities through a focus on the educational needs of counsellors. Sexuality is a concern that affects all potential clients, but the experience of sexuality is unique for clients with disabilities due to widespread taboos and false beliefs, as well as physiological and emotional effects of specific disabilities on the experience of sexuality. It is of particular importance to counsellors that future research focuses on the educational needs of professionals related to sexuality and disability. Specific training in this area will allow counsellors to work with clients around sexuality in a competent, comfortable, beneficial, and ethical manner.

Despite the clear need for such educational opportunities, counsellors receive limited training on sexuality and disability, and counsellors often hold negative attitudes about sexuality and disability (Booth et al., 2003). Little research has been done that outlines the unique counselling needs of clients with developmental disabilities, but this knowledge is crucial for providing effective counseling to clients with disabilities (Kanellakis, 2010). In a review of disability research and how it relates to counselling

psychology, Foley-Nicpon and Lee (2012) found that counsellors rarely had specific competencies in working with people with disabilities, and research in counselling often excludes this population. Graduate level counselling and clinical psychology students in Canada also have limited exposure to information and opportunities to develop competence about working with clients with disabilities (Weiss, Lunsky, & Morin, 2010), and graduate level clinicians in the United States are similarly unprepared to work with clients who have disabilities (Nezu & Nezu, 1994). The importance of education regarding sexuality and disability cannot be overstated. There are serious risks for people with disabilities that can result from a lack of education and support regarding sexuality, including an increased risk for sexually transmitted diseases; increased risk of unplanned pregnancies; vulnerability to sexual assault and exploitation; and negative attitudes such as fear and shames (Rousso, 1993). Given that people with disabilities have limited knowledge around sexuality, discomfort or unwillingness to explore sexuality-related issues in counselling poses a potential risk to clients and is arguably unethical (Leutrar & Mihokovic, 2007; Canadian Psychological Association, 2000).

Despite limited available research on sexuality and disability, the attitudes and competencies of counsellors, and how these attitudes impact the way that counsellors work with people with disabilities, there has been an ever-rising shift towards focusing on positive, strength-based models (Schwartz, 1988) in supporting people with disabilities. Evidence of the push towards a greater foundation of knowledge is the existence of journals dedicated to this subject, such as *Sexuality and Disability*. However, clinical practice continues to reflect historical beliefs that sexuality among people with disabilities should be discouraged (Ducharme, & Gill, 1990). Counsellors who prepare

themselves for working with clients with disabilities generally, and specifically regarding sexuality, are situated to be strong allies and advocates for people with disabilities and their families

Sexuality and Disability

As counsellors, an understanding of the concerns that face individuals with disabilities regarding their sexuality will inform effective practice. Support surrounding sexuality typically falls on service providers and support workers, but service providers often lack the resources to provide this support, and support workers often lack the education and willingness to engage in discussions around sexuality. It is important to note that although the trend in Canadian disability services is towards focusing on quality of life, the area of sexuality and romantic relationships is often avoided or ignored in practice (Bazzo, Nota, Soresi, Ferrari, & Minnes, 2007). Working with people with disabilities around sexuality is typically related to working with sexual behaviour that is considered challenging, although what constitutes challenging sexual behaviour is unclear (Lockhart, Guerin, Shanahan, & Coyle, 2009).

Individuals with disabilities face a unique set of concerns relating to sexuality, including social isolation, limited educational opportunities, and dependence on parents or legal guardians for support and decision-making. These myths and stereotypes are perpetuated in public health education because public health education typically fails to address sexuality and disability (Low & Zubir, 2000). Murphy and Elias (2006) argued that due to complex medical concerns that are often connected with disability, there is little available time or resources that professionals can use to discuss anatomic, physiological, emotional, and social aspects of sexuality with adolescents who have

disabilities. Although Murphy and Elias specifically encouraged pediatricians to engage in conversations with patients about sexuality, the suggestion that sexuality education should be actively provided to adolescents and children with disabilities impacts a range of medical and paramedical professionals. Suggesting that sexual development is not limited to physical functioning, Murphy and Elias argued that sexual education should incorporate a range of topics, including gender, physical maturation (e.g., puberty), body image, social relationships, and future aspirations related to sexual and romantic life (e.g., a future desire to get married). Importantly, Murphy and Elias argued that teaching children and adolescents with disabilities about sexuality, sexual self-care, and other skills necessary for a healthy sexual life are normal, necessary components of promoting independence, health, and self-esteem.

As noted previously, the factors inhibiting the exploration of sexuality of people with disabilities are complex, and there are a myriad of factors that limit support for people with disabilities in the areas of sexuality and romantic relationships, including the specific concerns that impact individuals with disabilities in their sexuality, discomfort with sexuality education, myths and stigmatization of disability and sexuality, and a lack of training of service providers and support workers. The following section will examine each of these concerns in more depth.

Isolation. Individuals with disabilities are generally isolated from individuals without disabilities, due to high support needs, limited involvement in community groups and events, and the stigma that is attached to disability (Bazzo et al., 2007). As a result, individuals with disabilities generally develop social relationships within their professional support systems with fellow clients or support workers. The range of

possible relationships is typically limited to environments in which very close supervision and support are provided, limiting the opportunities of people with disabilities to meet potential sexual and romantic partners. Even in situations in which an individual with a disability has access to a variety of different social outlets, stigmatization is a major factor in the limited options of sexual and romantic partners available.

Chivers and Mathieson (2000) noted that high levels of social isolation of individuals with disabilities is reinforced by the focus of service providers and educators in disability services on biological functioning, to the exclusion of social benefits of romantic and sexual fulfillment. For example, very little discourse about sexuality, intimacy, desire, and pleasure occurs between service providers, support workers, and individuals with disabilities. When discourse does occur, it is typically male-centric, with an importance placed on penetrative, heterosexual sex, reinforcing the belief that if an individual is not capable of penile-vaginal intercourse, that individual is asexual (Chivers & Mathieson, 2000).

Social isolation increases vulnerability, potentially as a result of the invisibility of issues that affect people with disabilities. For example, social isolation has been linked to increased rates of sexual assault (Andrews & Veronen, 1993; Suris, Resnick, Cassuto, & Blum, 1996). Sobsey (1994) presented the integrated ecological model of abuse which argued that support professionals, who are part of the cultural context of people with disabilities, influence responses to sexual victimization of the general community through role-modelling. This conclusion was later confirmed by Robinson and Chenoweth (2011). Hickson, Khemka, Golden, and Chatzistyli (2013) reported that abuse prevention

training is a necessary factor in reducing the vulnerability of people with disabilities. The factors that increased vulnerability were limited ability to recognize risk, limited training and skill-building opportunities for abuse prevention, limited self-empowerment skills, social expectations to conform to authority, learned helplessness, and a desire to be liked or wanted that is not fulfilled due to limited social opportunities.

Support professionals play a pivotal role in increasing skills and knowledge surrounding abuse (Hickson et al., 2013; Robinson & Chenoweth, 2011), but support professionals also play an active role in addressing the social isolation of the people they work with (McConkey & Collins, 2010; Bazzo et al., 2007), through discourse that is open, progressive, and focuses on both emotional and physical aspects of sexuality (Chivers & Mathieson, 2000).

Lack of education. Gomez (2012) argued that individuals with disabilities lack regular and accurate education surrounding sexuality and intimate relationships, and this can be attributed to a fear of discussing sexuality based on myths that people with disabilities will be sexually abused or sexually abusive as a result of this education. Informal education options are also limited, as people with disabilities often live in prohibitive environments in which social relationships are not established, primary support is provided by individuals with limited education in sexuality, and the fear that sexuality education will result in negative outcomes. McCabe (1999) found that individuals with disabilities have less knowledge about sexuality compared to individuals without disabilities. More specifically, people with disabilities have been reported to have less knowledge about pregnancy, masturbation, contraception, sexually transmitted

infections, types of sexuality, social situations in which sexuality is appropriate or inappropriate, and legal issues surrounding sexuality (Murphy & O'Callaghan, 2004).

The lack of sexuality education provided to individuals with disabilities represents a major problem. As discussed in the previous section, vulnerability to sexual abuse is linked to limited sexual and communication skills (Sobsey, 1994). Sexuality education allows individuals with disabilities to recognize inappropriate sexual advances, effectively report incidences of sexual abuse, and reduces vulnerability and inappropriate sexual expression (McCabe, 1999; Swango-Wilson, 2008; Tarnai, 2006). Although sexuality education is sometimes provided based on an individual's level of physical or cognitive impairment, it is important that education programs and support surrounding sexuality be age appropriate and focused on sexual expression as a normal part of adult life (Chivers & Mathieson, 2000; Katz & Lazcano-Ponce, 2008; Low & Zubir, 2000). Addressing sexual issues in general, as well as those issues that commonly affect the safety and well-being of people with disabilities, is a necessary component of increasing independence and self-care skills, decreasing vulnerability to abuse, and addressing stigmatizing beliefs that are held by the overall community (Robinson & Chenoweth, 2011; Summerville & McKenna, 1998; Szoloz & McCabe, 1995)

Dependence on parents and guardians. For many people with disabilities in Canada, decision-making is at least partially the responsibility of parents or legal guardians. As a result, service providers and support workers are limited in the kind of support they can provide to enhance romantic and sexual fulfillment (Fader Wilkenfeld, 2011). For example, if a parent or legal guardian disapproves of discourse or activities that serve to enhance sexual and romantic fulfillment, the individual will likely be very

limited in the education and support they receive (Evans, McGuire, Healy, & Carley, 2009). As noted previously, parents can hold limiting and stigmatizing beliefs about sexuality and disability, and these beliefs impact parents' and guardians' acceptance of sexual relationships, thereby informing the decisions that parents and guardians make.

The involvement of parents and guardians in the decision-making of people with disabilities poses unique challenges for counsellors working with people who have disabilities. Individuals with disabilities experience a lack of privacy as a result of dependence on families, guardians, and support workers (Gomez, 2012), and this affects ethical considerations such as confidentiality and informed consent. Counsellors who wish to provide support to clients who are experiencing issues related to their sexuality are tasked with informing legal guardians of the importance of open, nonjudgmental discussion of sexuality, protecting the confidentiality of clients with disabilities, and advocating for changes in public attitudes and policies about sexuality and disability.

Counselling Clients with Disabilities

The life experiences of people with disabilities are uniquely influenced by a personal and social focus on disability as the primary component of their identity. As a result of personal factors that contribute to disability, widespread beliefs about disability, and social experience, people with disabilities have unique mental health needs (Lennox, Beange, & Edwards, 2000; Porat et al., 2012). Unfortunately, many of the mental health needs of people with disabilities are unmet, due to the unavailability of effective, informed services. In particular, mental health services for people with disabilities are too often sub-par (McCarthy & Boyd, 2002). Although one's disability is not the primary, nor the most important factor of his or her identity, disability can impact every

area of one's life. Any counsellor who wishes to gain competency in working with people who have disabilities are tasked with reflecting on his or her own biases, gaining an understanding of how disability impacts lived experience, and the interventions that are most effective with clients who have disabilities.

Reasoning errors. As previously discussed, counsellor education regarding sexuality and disability is lacking, and counsellors themselves are guilty of holding and perpetuating stigmatizing beliefs. Beyond limited knowledge and skill in working with people with disabilities in a counselling setting, counsellors are also subject to errors that decrease the effectiveness of the counselling services that are provided. Errors that decrease the effectiveness of counselling for people with disabilities are often related to the use of faulty heuristics, including the availability and representativeness heuristics, the fundamental attribution error, and labelling (Morrow & Deidan, 1992). Availability and representativeness heuristics are used to determine the likelihood that a particular situation will occur. An availability bias is a tendency to judge experiences as more or less common than they really are, such as in beliefs that sexually inappropriate behaviour will occur in all situations in which individuals with disabilities are educated about sexuality. The representativeness heuristic involves categorizing information based on how well that information meets specific criteria; criteria are typically established based on stereotypical beliefs. For example, a counsellor may funnel information provided by a client through what he or she believes about the particular disability that the client has, rather than viewing the information in an objective manner. Counsellors who are not aware of their biases around disability are at an increased risk of faulty reasoning through the availability and representativeness heuristics.

The fundamental attribution error is a discrepancy in perception between people who are actually involved in an event and those who observe the event. Typically those involved in the event attribute their actions to situational factors, while those who observe a situation attribute the actions of those involved to their personality traits (Morrow & Deidan, 1992). Counsellors may filter information about the experience of a client with a disability through the position of observer, thereby falsely attributing many of the factors of the client's experience through a belief that these situations are primarily the cause of personal factors of the client. Additionally, counsellor beliefs about client experiences can also be impacted by the perception of parents, support workers, and legal guardians. For example, a client who shares a story about a friend who touched him or her inappropriately may not receive appropriate support if the counsellor attributes inappropriate touching to a personality flaw of the client, rather than to situational factors such as a lack of knowledge about appropriate and inappropriate touching, or a lack of skills in advocating for one's rights.

Counsellors may inadvertently use prior knowledge and labelling to influence their understanding of a client's presenting problem (Darley & Gross, 1983). For example, access to previous medical information about a client could bias a counsellor's impression of a client and the interpretation of the information a client shares within a counselling session. Indeed, access to diagnostic information may provide important information to a counsellor working with a client who has a disability, but this information may also lead the counsellor to draw inappropriate or faulty conclusions about the specific needs of that client.

Finally, counsellors may engage in confirmatory hypothesis testing with clients who have disabilities, pursuing information in a way that influences the type of information that is shared (Strohmer & Shivy, 1994). Counsellors are likely to ask questions or initiate discussions that confirm the hypothesis they have already formed about their client's situation. The risk in counselling clients with disabilities is that counsellors may focus their questions on factors related to disability itself, rather than on other experiential factors such as age, religion, culture, or personal goals.

Developing a strong working alliance. With the emergence of movements to increase inclusion and normalization for people with disabilities, the proposed methods for counselling clients with disabilities have become more focused on the development of the working alliance, as opposed to rehabilitation measures (Brechin & Swain, 1988). Brechin and Swain noted that although the movement in disability services has been towards self-advocacy and inclusion, it is necessary to note that much of this self-advocacy requires professional help, which can be oppressive and dependency-inducing. It can be reasonably argued that counselling work should encourage and enhance efforts towards self-advocacy, rather than create different forms of restriction.

Rogers (1978) argued that the relationship between counsellor and client is of utmost importance in the process of personal growth, and many of the tools and strategies that have been developed to increase working alliance have been developed with clients who are able to speak and actively reflect on their experiences. Developing a client-centered working alliance that supports the process of inclusion and self-advocacy has been cited as the most important component of counselling clients with disabilities, with the development of goals arising naturally from this process (Brechin & Swain, 1988).

As such, Brechin and Swain (1988) proposed six principles that counsellors should consider in the development of a working alliance. A working alliance with a client who has a disability should: (1) be seen as an entitlement rather than an imposition by the client; (2) promote self-realization rather than compliance; (3) create choices rather than limiting options; (4) explore opportunities, relationships, and patterns of living that are in line with the client's wishes; (5) enhance decision-making and personal control; and (6) allow the client to move at the pace they are most comfortable with (p. 224). Counsellors who have developed a strong working alliance with clients can begin to develop an appropriate treatment plan, and can choose the methods or interventions that are most applicable to the client's needs.

Therapeutic methods and interventions. Commonly, the primary purpose of counselling for clients who have disabilities is to address "behavioural issues." Often, these issues are identified by support staff as being problematic, due to health and safety concerns for the client or others (Lovett, 1985), or due to culturally prescriptions of appropriate behaviour. As such, behavioural or cognitive-behavioural therapies are often used to affect change in unsafe, aggressive, or socially inappropriate behaviour (Taylor, Novaco, Gillmer, Robertson, & Thorne, 2005; Taylor, Novaco, Gillmer, & Thorne 2002). Other approaches are utilized in counselling clients with disabilities, often with adaptations to ensure that the interventions are understandable and relatable to people with disabilities (Mansell & Sobsey, 2001) such as person-centered therapy and solution-focused therapy (SFT). Following is an exploration of the use of each of these approaches in counselling people with disabilities.

Cognitive-behavioural therapy. Cognitive-behavioural therapy (CBT) addresses the interaction between cognitive processes, emotions, and behaviors, and aims to find and correct faulty cognitive processes that are connected to maladaptive behaviour and distressing emotional states (Beck, 2011). CBT has long since been considered effective for the use with a variety of clients, including those with disabilities. However, Stenfert Kroese, Dagnan, and Loumidis (1997) noted that CBT with individuals who have disabilities is often missing the crucial, collaborative component, and that these goals are often developed by the counsellor, rather than as a joint process including the client. Some concerns have arisen over the past few decades regarding the ability of people with cognitive impairments to engage in CBT with most concern pointing to potential issues in self-reported behaviours and thoughts. However, in comparing staff-reports and clients' self-reports of their own behaviour, there is strong consistency, suggesting that clients with disabilities are likely capable of accurately self-reporting their behaviour and thoughts (Voelker et al., 1990).

Person-centered therapy. Person-centered therapy, originally made popular by Rogers (1951), places utmost importance on the relationship between the client and the counsellor, and suggests that this relationship is the foundation for client change. Person-centered approaches may be a strong method for addressing the lack of opportunity for emotional expression that many people with disabilities experience (Demanchick, Cochran, & Cochran, 2003). Person-centered approaches are a possible way in which to enhance client support by focusing on life participation, involving clients in decision making, and working towards life goals (Duchan & Black, 2001). Person-centered approaches also encourage counsellors to focus on an individual client's strengths,

abilities, and needs within the counselling setting, mitigating the problem that people with disabilities are often seen as unable to engage in psychotherapy and achieve benefits (Hurley, Tomasulo, & Pfadt, 1998).

Solution-focused therapy (SFT). Solution-focused therapy is a postmodern therapeutic approach that emphasizes client strengths and proposes that people are capable of resolving their problems because of these strengths (DeJong, 2002). SFT also suggests that clients are resilient to difficult experiences and that they will cope and continue to grow and develop (Selekman, 1997). The goal of SFT, then, is to collaborate with clients to identify their strengths and the tools they are already using that helps them manage emotional distress occurring from life situations, and does not pathologize clients or their experience (Greene, Lee, Trask, & Rheinscheld, 2005). SFT is arguably an effective approach for counselling people with disabilities, because the focus is on unique personal strengths, rather than on limitations and barriers, and disability does not negate personal resiliency and strength. As a result, SFT may be empowering for clients with disabilities, as illustrated by Greene and colleagues (2005):

...asking the client to do more of what he or she is already capable of doing can strengthen the therapeutic relationship because the clinician is not asking the client to do something unfamiliar; the client is likely to get the message that he or she is okay and is not deficient or in need of 'fixing'. (p. 68)

SFT assumes that: (1) every client is unique, and therefore his or her solutions will be unique; (2) clients have strengths and an inherent ability to help themselves; (3) no situation is fully negative; (4) counsellors do not label client's behaviour as positive or negative, but simply aim to interact in a way that allows the client to use a new response

that creates a more adaptive pattern; (5) counsellors cannot change clients, but clients can change themselves; (6) although SFT is relatively brief in comparison to long-term approaches (e.g., psychodynamic), SFT can and should be a process that occurs slowly and at the pace of the client; (7) cause and effect is not acknowledged, because problems are seen as unpredictable events; (8) solutions are of greater focus in counselling than problems, and solutions are not necessarily connected to problems; (9) emotions are a component of every problem and solution, and affect the language the client uses to interpret problems and solutions; (10) change is inevitable and continual, and build upon previous changes (Kral & Kowalski, 1989); and (11) the focus should be on the future rather than the past, as clients cannot change their past (Lipchik, 2011).

Lipchik (2011) described a theory of SFT that highlights the value of solution-focused approaches in work with clients who have disabilities:

Human beings are unique in their genetic heritage and social development. Their capacity to change is determined by these factors and their interactions with others. Problems are present life situations experienced as emotional discomfort with self, and in relation to others. Change occurs through language when recognition of exceptions and existing potential strengths create new actions. (p. 14)

If these assumptions are taken to be true, several aspects of SFT are potentially beneficial with clients who have disabilities. First, this theory recognizes that people who have disabilities, like everyone else, have a unique set of skills and barriers that impact their ability to change. Second, by viewing problems as current life situations, those problems are not attached to clients as personal failings, aspects of their disability, or the fault of an

external person, and it focuses the goals of therapy on those things that clients can currently control. Finally, through the exploration of exceptions and a focus on personal strengths, the ideal outcome of SFT is that of action. Combined, SFT brings together the positive aspects of person-centered approaches (i.e., a collaborative working alliance in which the client is in control) and CBT (i.e., challenging defeating thoughts translates into changes in behaviour).

Counselling Clients with Disabilities Regarding Sexuality

Counselling can be utilized to resolve a variety of concerns and issues regarding sexuality, including increasing physical and emotional awareness, practicing assertiveness and negotiating permission for sexual activity, sexual education, and exploring concurrent psychiatric concerns such as anxiety and depression that impact sexuality (Leiblum, 2006). Furthermore, discourse around sexuality is a much needed component of the support that people with disabilities receive. Given that counsellors are likely to work with clients with disabilities at some point in their career, and that issues of sexuality will likely arise, it is very important that counsellors reflect on their personal attitudes and beliefs, competency, and knowledge surrounding disability and sexuality (Lemon, 1993). The following section will explore in depth the specific factors that impact the effectiveness of counselling for people with disabilities who have sexuality-related concerns.

Unfortunately, limited research on disability and sexuality is available (Kanellakis, 2010), and clients with disabilities may be limited in their access to and ability to engage in counselling regarding sexuality. Limitations in personal power and self-determination can limit an individual's ability to engage in counselling

(Raffensperger, 2009), while lack of education regarding sexuality can further limit an individual's ability to engage in counselling to address these needs. Most of the research outlining quality of life and sexual satisfaction among people with disabilities is related to physical disabilities (e.g., Kreuter, Sullivan, & Siosteen, 1996; Milligan & Neufeldt, 2001). This represents a major gap in the research, as clients that a counsellor encounters in practice may have a cognitive disability, or their disability may not be visible (i.e., a disability that is not immediately apparent based on physical features). Without sufficient training, counsellors are at risk of unknowingly causing harm to clients. In order to act according to ethical guidelines, counsellors should increase their knowledge and understanding of disability and sexuality.

Supporting an individual with a disability to explore his or her sexuality and the possibility of sexual or romantic relationships requires a variety of personal traits and competencies, including: self-awareness of personal biases, fears, or gaps in education (Chivers & Mathieson, 2000); a nonjudgmental attitude; and a personal commitment to increasing knowledge and skills. Working through personal biases towards disability and sexuality is a necessary component for any counsellor who chooses to approach this topic with clients. Darley and Gross (1983) argued that biases can lead to the use of ineffective or inappropriate interventions, misdiagnosis of presenting problems, and an overall exacerbation of client problems.

Common presenting problems. Counsellors working with sexuality and disability are likely to encounter several general sexuality-related issues in practice which are explored in-depth below, including physical sexuality, exploration of sexual orientation, issues resulting from sexual abuse, self-esteem relating to sexuality, concerns

regarding availability of potential partners, developing the skills necessary to negotiate a sexual or romantic relationship, and learning to flirt or negotiate sexual relationships. In addition to these areas, counsellors may also encounter concerns regarding sexual dysfunction due to physical ability or medication effects (Gomez, 2012), parenthood and parenting rights (Areschoug, 2005), and issues related to transitional periods, such as from childhood to adolescence, or from adolescence to adulthood (Hallum, 1995).

Physical needs. Unsurprisingly, masturbation is commonly the primary sexual outlet of individuals with disabilities (McCabe, 1999; Gomez, 2012). Ludlow (1991) suggested that masturbation is one of the only means that individuals with disabilities have to cope with persistent boredom and restrictions in living environments. Masturbation is a beneficial activity, although it does not fulfill the sexuality needs of many individuals with disabilities. Despite the normalcy and relative safety of masturbation, engagement in masturbation is commonly viewed as a “behaviour of concern” by service providers, support workers, and families of people with disabilities. As a result, masturbation may be a topic that clients have very little understanding of, and that guilt and shame is attached to.

Gomez (2012) reviewed the issues that may impact people with disabilities’ access to and experience of sexual activity. Several factors can impact one’s ability to engage in sexual activity, such as particular impairments, disorders, or medications. For example, medications such as neuroleptics and antipsychotics contribute to sexual dysfunction. Multiple sclerosis, Parkinson’s disease and spinal cord injury have all been studied regarding sexual side effects, and issues of pain, numbness, fatigue, balance, and

body image all impact each of these illnesses (Esmail, Munro, & Gibson, 2007; Kool, Woertman, Prins, Van Middendorp, & Geenen, 2006; Wiwanitkit, 2008).

Sexual orientation. Exploration of sexual orientation is an area in which many people with disabilities have very limited support, in part due to the stigma that exists around homosexuality and bisexuality (Cuskelly & Gilmore, 2007; Swango-Wilson, 2008; Yool, Langdon, & Garner, 2003). Astoundingly, Trudel and Desjardins (1992) reviewed nineteen studies regarding staff attitudes about the sexual behaviour of people with intellectual disabilities, and it was found that homosexual behaviour was commonly viewed as unacceptable, a finding that continues to persist (Abbot & Howarth, 2007). Although some headway has been made in recent years regarding the awareness of the sexuality issues that face people with disabilities, this research has been heteronormative in nature.

Lesbian, gay, bisexual, and transgendered (LGBT) people who have disabilities face stigmatization due to both their disability and their sexual orientation. Abbott and Howarth (2007) argued that LGBT people with disabilities have unique support needs, although the staff who provide support to people with disabilities are less willing or able to address issues related to homosexuality, bisexuality, or gender expression than heterosexual sexual education. The results of Abbott and Howarth's study suggested that staff were more comfortable addressing sexuality concerns that were specifically brought up by clients themselves than proactively addressing sexuality concerns with clients. Furthermore, this study reported that staff were less confident addressing lesbian, gay or bisexuality than heterosexuality. Aptly, Abbott and Howarth argued that people with

disabilities may refrain from asking questions about sexuality if they are not aware that it is both safe and necessary to ask questions regarding sexuality, or to discuss sexuality.

Bias against LGBT exists in therapy as well as in other forms of professional support, although it has been shown that clinicians have fairly positive attitudes towards LGBT people and have been fairly helpful in providing services to LGBT clients despite the lack of education surrounding LGBT issues in graduate-level counselling programs (Alderson, 2004). Increasing competence and comfort in addressing LGBT issues in counselling has been found to be associated with personal contact with LGBT people (Herek, 1994; Herek & Glunt, 1993; Waldo & Kemp, 1997). Dillon and Worthington (2003) developed five competencies that will allow counsellors to explore LGBT issues in a therapeutic setting: (1) knowledge of LGBT issues, including current events, modern discourse regarding LGBT rights, and research that elucidates the experiences and needs of LGBT people; (2) advocacy skills; (3) sexual identity development; (4) developing a strong working alliance with LGBT clients; and (5) issues affecting the assessment of LGBT clients (p. 247). These competencies can be utilized with clients who have disabilities and are members of the LGBT community, and also represent necessary competencies for counsellors working with clients around sexuality exploration in general.

Self-esteem. Given the myths and stigma associated with disability and sexuality, it is not surprising that individuals with disabilities may struggle with self-esteem. Addlakha (2007) noted that people with disabilities are generally perceived to be less sexually desirable than people without disabilities, and this is likely to lead to a person with a disability feeling unattractive and sexually incompetent. The message that is

received by individuals with disabilities regarding sexuality is that they should not be sexual, that they are not viable sexual partners, or that their experience of sexuality is inappropriate or problematic. As a result, working through the internalized beliefs about sexuality is likely an important component of counselling for clients with disabilities.

Sexual trauma. Individuals with disabilities are subject to shockingly high levels of sexual abuse (Baladerian, 1991; Brown, Hunt, & Stein, 1994), and this abuse is associated with low self-esteem, anger, and depression (Peckham, Howlett, & Corbett, 2007). Vulnerability to sexual abuse is a consideration that impacts the work that counsellors do with clients who have disabilities. Working with clients with disabilities around abuse prevention is a necessary component in reducing vulnerability to abuse (Hickson et al., 2013). Hickson and colleagues also identified a variety of factors that increase vulnerability to sexual abuse, including limited ability to recognize and manage risky situations, limited self-empowerment skills, a need to be liked or wanted, a strong desire for friends and intimate relationships that has been unmet, social expectations to conform to people in positions of authority, and past sexual abuse. Further risk factors for abuse include limited sexual education, socialization that places importance on compliance, dependence on others, and poverty (Barger, Wacker, Macy, & Parish, 2009).

Abuse prevention programs and efforts should meet several criteria in order to be effective, as developed by Morrissey and colleagues (1997). Abuse prevention efforts should be (1) inclusive of the systems that impact the client, including family and friends; (2) grounded in a theoretical model that is consistent across individuals involved; (3) intensive and regular; (4) specific to the needs of the individuals, including considerations for age, communication ability, support needs, and cognitive functioning;

(5) focused on the development of skills; (6) followed-up on regularly; and (7) involve the input of those that are served by these efforts (p. 372). In areas that are lacking sexual abuse prevention programs that impact people with disabilities, counselling offers an alternative means to meet the needs of clients that are at risk for sexual abuse.

Counselling clients with disabilities who have experienced sexual abuse has been found to be effective through a variety of interventions. For example, group psychotherapy for female sexual abuse survivors was found to increase clients' knowledge about sexual issues, and decrease reported depression (Peckham, Howlett, & Corbett, 2007).

Additionally, Dolan (1991) argued that solution-focused therapy (SFT) is potentially effective in working with survivors of sexual abuse, harassment, and sexual assault. This work could include working through past sexual trauma, establishing skills for protecting oneself from sexual abuse and reporting sexual abuse that has occurred, and establishing what constitutes sexual abuse or inappropriate sexual behavior (Mansell & Sobsey, 2001).

Romantic relationships. As previously outlined, people with disabilities experience social isolation, loneliness, and stigma surrounding their viability as sexual or romantic partners. Given that romantic and sexual relationships are a desire for most people, issues surrounding acquiring partners, as well as concerns regarding current relationships, are likely to arise in counselling. In Alberta, some disability service agencies are beginning to offer group psychoeducational programs and educational programs around healthy relationships, although a review of these workshops indicates that the focus of the content is on safety and maintaining sexual boundaries. Counsellors have the opportunity to provide people with disabilities support in other areas relating to

romantic relationships, such as exploring emotions (e.g., jealousy), strong communication, and couples concerns. Chivers and Mathieson (2000) suggested that counsellors who work with people who have disabilities regarding their sexual relationships need to be self-aware, active in exploring their personal issues, and able to focus on both biological and emotional functioning with clients. Further, Healy, McGuire, Evans, and Carley (2009) identified that support should focus on sexual autonomy and sexual rights, managing barriers to fulfilling sexual relationships, and positive sexual expression.

Barriers to effective counselling. Effective, appropriate counselling for individuals with disabilities regarding sexuality is also impacted by factors related to counsellors. For example, Kanellakis (2010) noted that counsellor attitudes regarding disability were related to a reluctance of counsellors to discuss sexuality. Attitudes of counsellors with sexuality and disability impact the decisions that counsellors make around strategies and interventions, as well as the effectiveness of chosen interventions and tools (Aunos & Feldman, 2002; Wolfe, 1997). Guthrie (1999) also suggested that heavy workloads, lack of privacy in counselling, and a lack of comfort or confidence in exploring sexuality also limited access to sexuality counselling.

Counsellor competence. Generally, few training opportunities exist for counsellors to develop competence in sexuality counselling (Alderson, 2004). Furthermore, training opportunities for counsellors to work with sexuality and disability is equally limited; post-secondary education programs do not include training in sexuality or disability for counselling students in Canada (Weiss et al., 2010) or medical students (Parchomiuk, 2013). Although some training tools have been established to assist

counsellors working with disability and sexuality, these tools or workshops are primarily focused on physical disability and biological concerns with sexual organs (Booth et al., 2003). However, training in sexuality and disability increases competence and comfort in working with sexuality concerns for psychologists, social workers, physicians, nurses, physical therapists, and occupational therapists (Post, Gianotten, Heijnen, Lambers, & Willems, 2008). Weerakoon and Stiernborg (1996) argued that education in working with sexuality and disability should focus on increasing knowledge and skills rather than on attitude change, a finding that was confirmed by Post and colleagues (2007). Attitudes of service providers regarding sexuality and disability have been reported to be generally more liberal than the general population, although this finding relates specifically to people with disabilities that were acquired due to brain injury (Simpson, Anwar, Wilson, & Bertapelle, 2006).

Training has also been found to be related to more open-minded attitudes regarding sexuality and disability (Booth et al., 2003; Brantlinger, 1983; Fronek et al., 2011; Murray, MacDonald, & Minnes, 1995; Murray & Minnes, 1994). Comfort in discussing sexuality-related concerns with clients has been found to be related to age (i.e., younger professionals have more liberal attitudes; Brantlinger, 1983), religiosity (i.e., high levels of religiosity are correlated with conservative views; Almore & Weidner, 2002 as cited in Kazukauskas & Lam, 2010), and frequency with which professionals interact with clients (i.e., less frequent interactions with clients is correlated with more liberal attitudes; Kazukauskas & Lam, 2010).

Counsellor role. Although progress is made towards increased sexual rights for people with disabilities, clinicians, support workers, families, and physicians continue to

discourage sexuality and disability in practice (Ducharme & Gill, 1990). Counsellors are uniquely situated to use their expertise, skills, and experience to provide necessary support to people with disability regarding their sexuality in ways that other professionals are less able to provide. Access to sexuality counselling is limited, particularly for people with disabilities, and counsellors will need to incorporate issues of sexuality in to counselling (Swango-Wilson, 2008).

It is necessary to establish what the role of a counsellor in supporting clients with disabilities regarding sexuality typically is, and the ways in which a counsellor can impact a client's life in a positive way. Counsellors are involved in exploring sexuality concerns, how the client experiences their disability and their sexuality, working through past sexual trauma, and establishing skills for approaching sexuality and sexual decision-making. Counsellors are also an integral part in facilitating the development of strong self-esteem and confidence, working through issues that arise from personal and social limitations, exploring skills and competencies that are required for the development of sexual relationships, and some sexual education (Parchomiuk, 2013). Counsellors may also have a role in advocating for the sexual rights of clients to support workers, families, and the community at large.

Establishing a strong working alliance with clients is one of the most important factors of effective counselling. Establishing a strong working alliance with clients who have disabilities may require special considerations. For example, issues of transference arise in counselling often, but working through transference issues with clients with disabilities may be particularly delicate. In the next section, I explore the special considerations that will inform clinical practice with clients who have disabilities.

Special Considerations. Several key ethical considerations are of utmost importance for counsellors who work with, or wish to work with, clients with disabilities regarding sexuality concerns. People with disabilities have unique experiences with issues relating to autonomy, self-determination, decision-making, as well as cultural experience, and counsellors are ethically obligated to be aware of these issues. Holiman and Lauver (1987) argued that “because a client may be, at best, unaware of [their] rights and, at worst, too vulnerable and demoralized to scrutinize the counselor’s behavior, counselors must take care not to erode the client’s integrity and usurp the client’s right to self-determination” (p. 184). Counsellors working with clients who have disabilities should take care to be advocates for their clients, making ethical decisions that incorporate an understanding of the personal and cultural impacts of disability on the client.

Informed consent. Informed consent is an important ethical consideration in working with clients with disabilities, specifically in ensuring that consent is gained only after clients are fully informed of the risks and limitations of counselling, their rights and responsibilities in attending counselling, and special considerations such as confidentiality. Informed consent requires the ability to understand relevant information, the ability to appreciate the consequences of informed consent, an understanding of the available options, and an ability to communicate choice. In Alberta, some people with disabilities will be legally independent, while others will have participated in a capacity assessment and deemed unable to make some kinds of decisions, including the decision to receive medical treatment (Office of the Public Guardian, 2008). In order to gain fully

informed consent, counsellors will require information about the extent to which clients are legally supported to make decisions, as well as the support of legal guardians.

The ability to legally provide consent for treatment does not determine the extent to which a counsellor should work with clients to gain their understanding of the therapeutic process and their rights as consumers. Horner-Johnson and Bailey (2013) reported that more than 50% of participants in a study about disability and informed consent were able to respond to all necessary questions and show an ability to understand the risks of involvement in the research study, although nearly 50% of participants struggled to answer at least one necessary question surrounding informed consent, typically surrounding the risks of counselling. Although dependent adults will have a legal guardian who may or may not be responsible for making decisions around medical care (including counselling), client-centered practice demands that informed consent be explored with the client in a way that is relational and understandable (Holiman & Lauver, 1987). When working with clients who have disabilities, issues of accessibility, language, and understandability are at the forefront of importance. For example, informed consent can be provided in plain language or available with images, and can be provided to clients in a way that allows a conversation to develop. There is a perception among counsellors that clients with disabilities are unable to provide informed consent, a determination that counsellors need to make carefully with each client they see (Horner-Johnson & Bailey, 2013).

Informed consent is an opportunity for providing people with disabilities an opportunity to engage in decision-making and to acknowledge the rights and autonomy of every client (Guess, Benson, and Seigel-Causey, 2008). Interestingly, engaging in

decision-making has been shown to enhance learning among people with disabilities (Monty & Perlmutter, 1975); supporting choice and decision-making among clients who have disabilities may increase their understanding of the information included in informed consent

Confidentiality. Confidentiality is of utmost importance in working with clients with disabilities. Although clients may be legally dependent (i.e., a legal guardian has been appointed to assist with decision-making), client privacy is necessary for the establishment of a strong working alliance. Under the ethical guidelines proposed by the Canadian Psychological Association, consent is signed by legal guardians; however, some clinicians protect the privacy of dependent adults by entering into a mutual agreement with legal guardians about what information should be shared and what information should remain private between the client and counsellor. Still, clients may have legal guardians or support workers who are actively involved in supporting clients to access counselling services, and this network of support brings their personal interests and attitudes to the counselling relationship. Counsellors must facilitate goals and use interventions that balance the self-exploration needs of the client with the needs of support worker and guardians to follow policies and create safety for clients.

Counsellor competence. As noted previously, little training is available for counsellors in working with individuals with disability regarding sexuality. Ethically, it is imperative that counsellors work in areas in which they have sufficient competence, so limited available training options contribute to the lack of available support for clients with disabilities (Hough & Squires, 2012). Hertzprung and Dobson (2000) argued that counsellors are ethically obligated to develop competence in working with individuals

with disabilities. Considering that sexuality is a normal component of adolescent and adult life for people with and without disabilities, gaining competence in working with sexuality-related concerns is an ethically strong decision for counsellors. Counsellors who are untrained are at risk for unwittingly discriminating against individuals with disabilities (CPA, 2000), by perpetuating stigmatization of people with disabilities or relaying discriminating attitudes to clients and the general population. VanZandt (1990) summarized what counsellor competency should include: “competent counselors are also aware of the social, cultural, psychological, and circumstantial environments surrounding their professional activities” (p. 244) A solid understanding of disability and ongoing professional development regarding the issues that affect people who have disabilities situates counsellors to be advocates for their clients within the counselling setting and in the broader community.

Cultural diversity. For people with disabilities, every aspect of life is impacted by disability, including social relationships, access to, and involvement in activities, community events, and education or employment, and the kind of support that is provided by counsellors, physicians, and other support professionals. As such, having a disability impacts the cultural milieu of clients, and is arguably a cultural identity itself. Counsellors who work from a multicultural perspective are more likely to positively impact client’s experiences in counselling, overall client welfare, and the client’s level of self-determination than counsellors who work from a monocultural perspective (Burn, 1992; Katz, 1985). Burn argued that ethical counselling requires counsellors to develop awareness of their clients’ cultural experiences, be willing to approach cultural issues in an open and honest way, and use any information about a client’s cultural experience as a

means to understand the client experience at a deeper level. Sue (2001) argued that multicultural counselling is wider-reaching than individual client-counsellor interactions; a focus on social justice issues and a recognition of the intersection of culture and various forms of discrimination is necessary to ensuring that equal access to inclusive, barrier-free service is provided to all clients.

Counsellors who work from a multicultural perspective seek to recognize issues of discrimination that may be affecting clients; for clients with disabilities, ableism is a foundational issue of discrimination and prejudice (Moore, 2002; Smith, Foley, & Chaney, 2008). Moodley (2007) argues a strong case for the importance of considering cultural milieu in counselling: “creating a ‘third space’ in counselling and psychotherapy, as an in-between space – a place of intersections, interconnections and cultural interpretations – where dominant hegemonic cultural meanings could be interrogated and reinscribed to empower marginalized voices, is both ethically and clinically necessary” (p. 9). Counsellors are well situated to facilitate the exploration of culturally grounded issues, such as discrimination, in ways that empower clients and create conversation. For clients with disabilities, this empowerment can be a rare opportunity.

Summary

In this chapter, a brief history of disability and rehabilitation in Canada is provided. From this history, modern conceptualizations of disability are presented. Understanding both the history of disability and rehabilitation in Canada, as well as current approaches to supporting people with disabilities, allows a greater understanding into the attitudes of service providers who work with people with disabilities. These attitudes impact the kind of assistance that is provided to people with disabilities, as well

as their social interactions. In particular, attitudes regarding sexuality and disability play a major role in the social, recreational, and emotional well-being support that people with disabilities receive. In this chapter, the myths and stereotypes regarding disability and sexuality are reviewed, and a summary of the current research regarding sexuality and disability is provided. For counsellors, the cultural context of those with disabilities plays an important role in the kind of therapeutic approaches that are most effective, and the specific barriers that might arise, in counselling people with disabilities. Further, specific concerns regarding sexuality and disability that may impact counselling work are highlighted, and several potential therapeutic methods are suggested for working with sexuality-related issues. Finally, ethical considerations for counsellors working with clients who have disabilities are presented and reviewed.

Chapter 3: Methodology

In partial fulfillment of the Master of Counselling degree with the University of Lethbridge, I developed a manual for counsellors to work with people who have disabilities around their sexuality concerns as my culminating activity. This manual was developed using information gathered from previous academic research regarding sexuality and disability, as well as some qualitative information that was informally gathered from counsellors, social workers, and other professionals that provide support to people with disabilities. In this chapter, I review the methodology that was followed to develop the manual. Specifically, I will examine how the literature review and manual were developed, how the knowledge I've gained will be shared with counsellors, service providers, and the overall community, and limitations and considerations regarding the scope of this manual.

Literature Review

The topics covered in the literature review portion of this project have been identified as necessary for the development of this manual through review of peer-reviewed, academic research. Specific topics that were identified throughout the literature review include the history and experience of people with disabilities in Canada, common myths around disability and sexuality, factors that impact the effectiveness of counselling clients with disabilities and clients who present sexuality-related concerns, the current base of knowledge surrounding sexuality and disability, as well as the ethical implications of counselling clients with disabilities around sexuality.

Search topics were created and entered into general internet search engines (e.g., Google), as well as the University of Lethbridge's library database system in order to find relevant peer-reviewed journal articles relating to sexuality, disability, and counselling.

Search terms included *sexuality and disability*, *disability counselling*, *sexuality counselling*, *disability rehabilitation*, *ethics and disability*, *sex therapy*, *quality of life*, *disability history*, and *attitudes and disability*. After carefully reviewing each article, additional resources and important topics were identified. In addition to peer-reviewed journal articles, books and theses were identified and reviewed. Each seminal or major resource that was incorporated in the literature review was reviewed using a Vee diagram (Novak & Gowin, 1984), which is a tool that allows each reported study to be summarized and critiqued in a methodological manner. Reviewed resources were organized and summarized using a self-created database system consisting of the article reference, research question, methodology, results, and main arguments. The major themes for each article were identified in the database system, which allowed patterns and links between themes to emerge. The database provided a clear picture of the current research in each subtopic, as well as an efficient view of the patterns of research and the areas of further research that are required (Leedy & Ormrod, 2013). The patterns that emerged from the literature review served as an outline for the literature review portion of this proposed project.

Qualitative Information

Given that the primary purpose of this manual is to provide counsellors with a tool that will increase both competence and comfort in working with clients who have disabilities and present sexuality-related concerns. In order to determine some of the professional development needs of counsellors who work with clients who have disabilities, several professional counsellors were approached with informal questions about their experiences. Although the number of counsellors that were approached was

limited, speaking directly to counsellors currently working in the field provided a strong justification for the usefulness of the manual, as well as rationale for the information provided in the manual. These informal interviews included information gathered in a qualitative review of current issues affecting clients with disabilities (Gothreau, 2013), personal correspondence with clinicians and researchers specializing in sexuality counselling and disability counselling, and conversations with counsellor colleagues at conferences.

Development of the Manual

In an effort to gain insight in to the most effective format of the manual, other counselling manuals were reviewed. Strengths and limitations in organization, structure, and language were noted. In addition to counselling manuals, disability service manuals were also reviewed, as these manuals provide detailed information regarding effective practices in supporting clients with disabilities.

As noted previously, the topics included in the manual were determined from the literature review to ensure that the manual is consistent with current literature. Primary topics included: (1) a discussion of the cultural biases and values that influence our understanding of sexuality and disability, including exercises for counsellors to explore their personal beliefs and biases; (2) an exploration of the myths surrounding disability, particularly regarding sexuality; (3) an outline of counselling practices that have been shown to be effective in working with clients with disabilities; (4) an outline of the counselling practices that have been shown to be effective in working with clients with sexuality-related concerns; and (5) an examination of ethical issues related to counselling clients with disabilities, particularly regarding sexuality. The outline was organized

according to subtopic, with special attention paid to practical exercises. For example, exercises that may be of use to counsellors in reflecting on their assumptions and biases, and potential interventions and counselling techniques were explored.

There were several concerns that arose in the development of the proposed manual. First, as noted previously, there is limited available research specific to the topic of counselling clients with disabilities around sexuality. The bulk of available research focused on professional development for people in support roles other than counselling, such as rehabilitation workers and nurses. In addition, much of the available research explored the needs of people with physical disabilities (e.g., spinal cord injury, brain injury), with relatively less work focusing on intellectual disabilities. Given the differences in challenges faced by individuals with physical or intellectual disabilities, and therefore the type of support these respective populations may require, specific working definitions were established and reported for use in the manual.

Second, it is necessary to note that this manual was developed according to the ethical guidelines posited by the Canadian Psychological Association (CPA, 2000), and from within an understanding of the disability service model used in Canada. In other cultures, views about disability and sexuality may be different, and counsellors from diverse backgrounds may approach work with clients who have disabilities differently. Additionally, the scope of practice of counsellors may vary in non-Western cultures.

Finally, given that the information that will be gathered and inform this manual will be insubstantial (Leedy & Ormrod, 2013), the interpretation of the information in this manual is prone to biases and assumptions. For an in-depth exploration of my biases and assumptions, please see Chapter 5.

Knowledge transfer

This manual is intended to provide an opportunity for counsellors to increase their competence and comfort in working with clients who have disabilities, specifically with sexuality concerns. I have provided details as to the benefit this manual provides to counsellors, but this manual also provides a substantial benefit to people who have disabilities, their families, support workers, and communities. Clients benefit from this manual as they will receive more effective support from counsellors and will have an increased opportunity to explore their sexuality in the counselling setting, ideally increasing wellbeing and quality of life. Given that counselling clients with disabilities around their sexuality reduces vulnerability to violence, sexually-transmitted infection, and unplanned pregnancy, as well as potentially minimizing sexually inappropriate behaviour (Mansell, 2002; Mansell & Sobsey, 2001), the people who provide support to clients with disabilities will also benefit from the development of this manual. Broadly, changing attitudes and dispelling myths about sexuality and disability will serve the greater community as well.

Much of the information provided in this manual could be informative for professionals who work with people with disabilities, as well as families, partners, and friends of people with disabilities. This manual will be available to counsellors and other supports through publication, as well as distribution to willing training facilities and universities. Additionally, the proposed manual was presented at a professional conference (i.e., a conference of counsellors from varying fields and backgrounds) in its infancy. Feedback from conference participants was utilized in the development of the manual.

Summary

This manual serves as my culminating activity in partial fulfillment of my Master of Counselling degree. As a budding counsellor with experience supporting individuals with disabilities, I place a great importance on understanding sexuality as a universal component of the human experience that plays a significant role in all people's lives, whether they are sexually active or not. The failure to explore these issues effectively and supportively within a counselling setting not only causes potential harm to clients, but perpetuates prejudicial and discriminating ideas about sexuality and disability. People with disabilities are stigmatized, particularly around sexuality, and this stigmatization leads to negative effects on wellbeing, mental health, and self-esteem. Despite these myths, it has been shown that people with disabilities are sexual, in a unique way, and that exploring sexuality provides benefits to people with disabilities. Given that counsellors are well-situated as confidential, trustworthy sources of support, counsellors should be prepared to work with clients who have disabilities regarding their sexuality. In order to develop this competence, counsellors will benefit from a manual that outlines the myths and stereotypes of sexuality and disability, the unique needs of clients with disabilities, and an opportunity to reflect on counsellor attitudes, techniques, and comfort with this area.

Chapter 4: Manual

Introduction

Sexuality is a universal aspect of human life and has an impact on overall quality of life. Regardless of external factors, people of every age, gender, ethnicity, cultural background, religion, and ability have an inner sexual life. Although many of us have access to education and experience that allow us to make safe decisions regarding our sexuality, people with disabilities are often excluded from these opportunities. This tendency to view people with disabilities as non-sexual beings increases the risk that a variety of harmful consequences will occur, including sexual victimization, social isolation, and health problems such as sexually transmitted infections and unplanned pregnancy. Although there has been a worldwide push towards the inclusion of people with disabilities in all areas of life, stigmatizing beliefs regarding sexuality and disability still persist, even within the circles of professionals who provide much needed supportive services to people with disabilities. It is clear that people with disabilities experience sexual desire and pleasure, biological arousal, and a desire for intimate and romantic relationships, but very little guidance is available for people with disabilities in how to explore their sexuality or work through sexuality-related concerns.

Counsellors typically have limited education regarding disability. The relative silence about disability in counsellor education perpetuates a problem in which people with disabilities have access to few resources for developing strong emotional well-being. There are relatively few counsellors with specialized training or experience in working with people with disabilities, seemingly due to a lack of awareness about the complexity of the issues that people with disabilities face within their lives. Research on the

counselling needs of people with disabilities, particularly those with sexuality-related concerns, has provided the basis of a strong argument for the immediate need for training materials that will guide how counsellors can most effectively work with clients with disabilities around these issues.

The issue of how sexuality is experienced by people with disabilities came into my view through my work as an advocate and supporter of people with developmental disabilities. Throughout my casework at various Southern Alberta agencies, I have encountered numerous people who face sexual challenges as a result of their disabilities. Many salient examples of these challenges come to mind when I reflect on those experiences. Very few of the people I've known experience sexual challenges that are related to their physical abilities; rather, these people experience extreme loneliness, social isolation, and deep sadness over the aspects of human life that seem unavailable to them. For some, body image and self-esteem are impacted by the daily stigma that they face and ongoing rejection from potential romantic partners. For others, the physical experience of sexual desire and arousal does not connect with their knowledge or understanding of their body, their sexuality, or their access to romantic partners. Regardless of the details of these stories, each of these people has been deeply impacted by disability on a social, romantic, and sexual level. However, for the clients that I have worked with, access to counsellors with a strong understanding of the cultural lens of disability is limited.

This manual serves as a step in addressing this gap in counsellor education, and serves to provide guidance to counsellors who work with people with disabilities, particularly regarding sexuality and intimate relationships. This manual explores the

myths and stereotypes around sexuality and disability that persist in Canada and impact counselling practices, the tools for self-reflection that will allow counsellors to identify the stereotypical attitudes they hold that could impact the work they do with clients, the counselling practices that could be used in working with clients who have disabilities, as well as the counselling practices that are effective in working with sexuality issues, and an exploration of the ethical concerns related to counselling clients who have disabilities. This manual is an important step in addressing the psychological well-being of people with disabilities, and serves as a means for ameliorating stigmatization and limiting attitudes that affect people with disabilities.

Purposes of the Manual. The goal of this manual is to provide information for counsellors that will allow them to work effectively and confidently with clients who have disabilities, specifically those who present sexuality-related concerns. Fronek et al. (2011) suggested that access to training and educational resources has long-term benefits for counsellors, and training that develops competence around disability concerns will enhance the skills that are necessary to broach sexuality comfortably with clients. However, despite the awareness of these benefits, very little information and education is available for counsellors working with clients who have disabilities around sexuality (Booth, et al., 2003). There are several goals that this manual aims to achieve, including: (1) to create awareness of the experiences of people with disabilities, including the pervasive stereotypes regarding disability and sexuality; (2) to challenge counsellors to reflect on their personal bias in order to allow for the creation of a nonjudgmental space for clients; (3) to highlight the counselling needs of people with disabilities; (4) to indicate the benefits of various therapeutic approaches and identify which approaches are

effective for counselling clients with disabilities; and (5) to contribute to the body of available research on disability and sexuality.

Benefits of the Manual. The potential benefits of this manual are numerous. First, this manual addresses an area in the lives of many people with disabilities that is wrought with abuse and coercion. People with disabilities are at a high risk for abuse of all kinds, and sexual abuse can have highly destructive effects, particularly without an outlet for addressing these experiences and working through them. In addition to abuse, without education and support about sexuality, people with disabilities are at an increased risk for unplanned pregnancies or contracting a sexually transmitted infection, fear and shame around sexuality, and low self-esteem (Murphy & Elias, 2006; Rousso, 1993). Given that the professionals who work with people who have disabilities role-model to others how to respond to sexual victimization, the interactions and attitudes about disability and sexuality of these professionals are critical (Sobsey, 1994). Training for counsellors in how to work with sexuality and disability is a key component of reducing the vulnerability of people with disabilities (Hickson, et al., 2013).

Second, this manual serves to increase awareness and understanding about the counselling needs of people with disabilities in areas that are often excluded from counsellor education and training. Counsellors who use this manual will benefit from the opportunity to engage in self-reflection about their personal biases and limiting attitudes. Several studies have found that those professionals who engage in professional development and personal reflection about their attitudes regarding disability and sexuality gain both comfort with discussing sexuality and competence in working with people with disabilities (Fronek, et al., 2011). Given that the role of a counsellor is to

facilitate change at both the individual and community levels, self-reflection enables counsellors to be effective in individual therapy, as well as effective advocates for social change in prejudicial beliefs.

Third, this manual serves to increase the competency of counsellors to work with people with disabilities in practice, regarding sexuality concerns as well as other concerns that may arise in counselling. A deeper understanding of the factors that impact quality of life and shape the unique experience of people with disabilities necessarily allows counsellors to connect with clients who have disabilities at a deeper level, developing a strong working alliance with them. This manual also provides counsellors with information that will allow them to navigate the demands of families and legal guardians as well.

Finally, this manual allows counsellors to reflect upon their personal beliefs and biases regarding sexuality and disability. These beliefs may be stigmatizing, and exploring these beliefs will allow counsellors to approach their work with clients who have disabilities in a more informed, comfortable way (Booth, et al., 2003; Murray, MacDonald, & Minnes, 1995; Murray & Minnes, 1994). This manual will ideally allow counsellors to gain increased comfort in addressing sexuality-related concerns with clients, as well as with their families or partners.

Definitions. The word *disability* carries a range of definitions and connotations across cultures, professions, and in current research. Throughout this manual the term *disability* encompasses any person who experiences physical impairments, limitations in executing tasks or engaging in activities, and restrictions in involvement in various life experiences (World Health Organization, 2002). As such, the recommendations in this

manual may be appropriate for clients who have physical disabilities (with limitations in the functioning of the body or parts of the body; e.g., spinal cord injury) or cognitive disabilities (i.e., *developmental* or *intellectual disability*; with limitations in intellectual capacity or adaptive skills). The World Health Organization definition of *sexuality* is also used throughout this manual and refers to the physical, psychological, and social experiences of sex, including the sexual body, sexual activities, sexual orientation or identity, and social roles related to sexuality. *Sexual health* is defined as “a state of physical, emotional, mental and social well-being related to sexuality” (WHO, 2002, as cited in Edwards & Coleman, 2004, p. 190).

The Experience of Disability

Take a moment to consider what life would be like if you had a disability. Imagine the experience of having regular support workers who are paid to push you to meet your goals. Imagine what it must feel like to have parents or non-family guardians make decisions for you about your health, money, friendships, recreational activities, or work. Imagine what it feels like to be viewed as incapable by those around you. In a climate of discrimination and dependence on others, people with disabilities have a unique experience that many of us struggle to understand. The lack of understanding contributes to many stereotypes that limit the opportunities and experiences available to people with disabilities. These stereotypes impact the access of people with disabilities to healthy, fulfilling romantic and sexual relationships. Attitudes about the sexual viability and attractiveness of people with disabilities contribute to the lived experiences of clients. For many clients, this experience is limiting and frustrating, as highlighted by Vicary (2014):

Almost every person with a disability can tell you of a time when they sought to express themselves sexually, only to be thwarted by those around them. It happened to me. I have cerebral palsy from birth, and my physical disability means I cannot independently dress, shower, feed myself or do any fine motor tasks. I can, however, socialise independently, speak my mind, study, work and pay taxes (para. 2).

As the above quote indicates, the lack of sexual life that many people with disabilities experience is the result of a complex variety of factors. The Disabled World website (2014) argued that the social ideals of what makes someone sexually desirable, combined with a lack of opportunity for sexual exploration, shaming from trusted people when sexuality-related issues are discovered, and a lack of sexual education are the primary ways in which people with disabilities are limited from fully recognizing their sexuality.

In their qualitative review of the relationship between culture and disability as it relates to sexuality, Yoshida, Li, and Odette (1999) found that people with disabilities in Canada had limited access to information about sexuality, were limited in potential social relationship partners, and experienced little sensitivity from health care professionals in approaching these topics. For example, one woman who participated in the focus group stated: “We have limited....really limited knowledge about sex and the family planning and those kind of things...even my mother or my sister, they won’t talk with me. They hesitate” (p. 330). Regarding the help of health care professionals, the participants reported that health professionals were contributing to the prejudicial stereotypes against people with disabilities. Another woman shared her story of seeking a doctor for her second pregnancy, who she recalls as insensitive (Yoshida, Li, and Odette, 1999):

[The doctor said] ‘See you have a disability. Do you want to get somebody else like [you] in this world?’ ...I sat there and I cried, because it was like no concern, nothing...Both my husband and I, we just sat and just listened to his voice...and don’t know what to do.” (p. 332).

Yoshida, Li, and Odette (1999) stated that “...for these women [with disabilities], there was no opportunity for open discussion on issues related to sexuality. Disability limited them in gaining access (sp) to information about sexuality” (p. 330).

Similarly, Kattari (2014) interviewed nine adults with disabilities about their sexual experiences. These individuals indicated that sexual education about sexual identity, sexual and romantic activities, relationships, safe sex practices, and family planning are crucially needed in order to meet the needs of people with disabilities. One participant, identified as Lyn, stated the importance of learning how to connect with her partners, a goal that counselors are well-equipped to work through:

...if I’m totally upfront with a partner, which I am now with a romantic partner, I think my sexual satisfaction increases, not only because they understand me, and my body, and what my limits are, and that they can change, but also just that confidence to be able to talk about my body in a really honest and direct way has led to increased sexual satisfaction. (p.506)

Myths and stereotypes. Harmful beliefs about people with disabilities continue to be perpetuated in the general community, among people who support those with disabilities, the family and friends of people with disabilities, as well as people who have disabilities themselves. Myths about sexuality and disability are perpetuated partly because of widespread failure to address disability in public sexual health education.

Disability is not discussed or acknowledged in public school education, which sends the message to both children with and without disabilities that people with disabilities are not sexual, or that their experience of sexuality is not unique. The relative silence about issues that affect people with disabilities, and the myriad of stereotypes that persist about disability, creates a cycle of oppression and silence that is difficult to stop. As a result, people with disabilities experience limited access to resources, employment and educational opportunities, increased dependence on professional supports, and discrimination from their peers. These factors increase vulnerability to abuse, coercion, isolation, and poverty (Holmes & McWilliams, 1981; Livneh, 1984; Scior, 2011). These pervasive stereotypes also impact the quality of medical and professional support that people with disabilities receive (Merkens et al., 1989; Tervo, Palmer, & Redinius, 2004). Fortunately, active efforts to increase education about disabilities have been shown to change the attitudes of those who work with people who have disabilities (Kazukauskas & Lam, 2010; Parker, 2012).

Several myths and stereotypes also limit the sexual experiences of people with disabilities. For example, people with disabilities are often falsely viewed as asexual (McKown, 1986; Milligan & Neufeldt, 2001). Feeding this view is the idea that people with disabilities have poor sexual functioning, cannot have orgasms, or simply do not desire love and sex. However, physical and mental impairments typically do not change the innate human drives for love, affection, and intimacy (Medlar, 1993; Nosek et al., 1996). In their expansive review of attitudes surrounding disability, Milligan and Neufeldt argued that a self-fulfilling prophecy is created as a result of these pervasive myths, in which people with disabilities internalize social attitudes, and sexual rejection

can lead them to a retreat from intimacy, which in turn perpetuates the myth that they are asexual. When efforts are made to discuss sexuality with people who have disabilities, these conversations are often androcentric and focused on penetrative, heterosexual sex, which feeds the belief that if a person is not able to engage in penile-vaginal intercourse, that person is asexual (Chivers & Mathieson, 2000). Alternatively, other pervasive myths suggest that people with disabilities are unable to control their sexual urges, (DeLoach, 1994; McCabe, 1993; Parchomiuk, 2013), and that any kind of sexual education will increase urges that are difficult to control by support staff and families. At the heart of this myth is an assumption that people with disabilities are unable to control their actions due to limitations in cognitive functioning.

Stereotypes about the parenting skills of people with disabilities are also pervasive, and impact people with disabilities on a variety of levels. Women with disabilities reported having poor experiences with health care professionals, a lack of support from family and friends, and threats from government agencies to take custody of a child born to a mother with a disability (Yoshida et al., 1999). Waxman (1994) identified the faulty belief behind issues of parenthood and family planning: “the very nature of disabled women’s biological and social bond with a child will result in the child becoming physically, socially, psychically and morally defective” (p. 156). Since the 1980s, women with disabilities have reported a need and interest in peer support groups for parents, as well as access to services that assist with pregnancy, childbirth, and parenting issues (Shaul, Dowling, & Laden, 1989).

People with disabilities are often defined by that disability, particularly as it relates to their viability and attractiveness as sexual or romantic partners. For example,

one woman who was participating in a focus group around sexuality and disability stated: “I wish we could just make it [sex and dating] more fun in some ways, instead of having our disability in the community define us...” (Kattari, 2014, p.406). It is generally believed that a disability is an undesirable trait in a sexual partner, and this belief seems to be connected to a taboo against choosing an individual with a disability as a romantic partner, or indeed even being attracted to a person who has a disability (Parchomiuk, 2013).

The question of how these myths are perpetuated is complex. A self-advocate for the rights of people with disabilities, Davies (2000) suggested that it’s an issue of visibility and public representations of disability:

The notion that we are hidden away it won’t have escaped your attention the lack of positive images of us – especially sexy, life affirming, passionate images. The power of role modelling and patterning on the psyche is important to our positive self-development (p. 185).

It appears that the sexual oppression of people with disabilities occurs both on a societal level and an individual level. As counsellors, we can address this issue in multiple ways, including through advocacy for our clients, professional development of ourselves, and in how we approach issues of sexuality with our clients. For sexual minorities, it seems that counsellor willingness to explore these issues and how they relate to multiple facets of one’s life are related to good client outcomes (Garnets et al., 1991).

Take a moment to stop and think of the beliefs that you have about people with disabilities. Where did these beliefs come from? Do you have the same beliefs about people with physical disabilities as you do for people with cognitive disabilities? What

beliefs do you hold about disability and sexuality? It is crucial to understand these stereotypes and how they affect our clients' experiences, as well as how our personal beliefs affect the work we do with our clients. If we are afraid to openly discuss sexuality with clients who have disabilities, we are part of the problem that keeps many people with disabilities from realizing their dreams.

The personal is political. Activist and researcher Siebers (2008) addresses issues of sexuality and disability from a very personal lens, as well as broader political lens. As an individual with a disability himself, Siebers combines his personal experience with his research into these issues, and argues that denying people with disabilities from counseling and education around sexuality is akin to robbing those with disabilities of their humanity. A focal argument that he makes is that discrimination often occurs at the level of sexuality, and people with disabilities have little control over their bodies due to institutional living conditions that regularly practice sexual repression and restrict intimacy. Siebers simply argues that one's control over his or her sexuality is central to his or her political agency, which is consistent with a particularly salient statement by Finger (1991):

Sexuality is often the source of our deepest oppression; it is also often the source of our deepest pain. It's easier for us to talk about-and formulate strategies for changing- discrimination in employment, education, and housing than to talk about our exclusion from sexuality and reproduction. (p. 9).

As a front man for "The Project," Davies aims to integrate the social and medical model as a means to develop practical ways to address issues in self, body, and sexual esteem for people with disabilities. In a conference presentation, Davies (2000)

highlighted the importance of counsellor involvement in advocating for people with disabilities' sexual rights: "Therapists should be more involved in political action. Therapy is a political act; we need to move away from 'individual pathology' models to recognition of the effect of social context on our lives" (p. 181). Davies continued to highlight the importance of therapy in addressing personal and political issues related to disability and sexuality:

We are disenfranchised, disempowered, and disabled, which leads to disrespecting our needs, our feelings and often our basic human rights. To conclude, my clinical training has taught me that therapy is about respect. Therapy is very often about the affirmation, and witnessing of the client's story. Good therapy is about learning to allow ourselves to be loved by the therapist and ourselves. Working with people to realise their potential is an immensely privileged position to be in, but the clinical context can have a place at the heart of the research agenda and the research agenda can importantly inform the clinical work we do. Therapists can and should do much more to be agents of social change, and can actively play a role in research. (p. 185).

Of utmost importance, however, is addressing these myths and stereotypes with people who have disabilities themselves. People with disabilities are typically not provided with effective support and education around sexuality and intimate relationships (Gomez, 2012), and therefore have less knowledge around their sexuality than people without disabilities (McCabe, 1999). This lack of knowledge increases susceptibility to abuse (Sobsey, 1994), while sexuality education (formally or in one-on-one support settings such as counselling) has been shown to decrease vulnerability. Specifically,

sexuality education increases the skills of clients to recognize inappropriate sexual advances, report sexual abuse, and decrease propensity to engage in inappropriate sexual expression (McCabe, 1999; Swango-Wilson, 2008; Tarnai, 2006).

Lewis and Bor (1994) identified the importance of access to non-judgmental environments for clients to discuss their sexuality concerns, and argued that professionals should acknowledge and challenge biases and prejudice around disability and sexuality. Avoiding exploration of sexuality concerns, particularly those related to the romantic and sexual fulfillment rather than biological functioning reinforces the social isolation of people with disabilities (Chivers & Mathieson, 2000). Counsellor perceptions of sexuality and disability also contribute to a reluctance to discuss sexuality with people who have disabilities (Guthrie, 1999; McKown, 1986; Milligan & Neufeldt, 2001). It is clear that counsellors can and do play an active role in addressing prejudice against people with disabilities, as well as perpetuating myths about disability and sexuality. As such, counsellors have a strong impetus, and arguably a responsibility, to reflect upon their biases, model appropriate support skills, and address these issues with clients.

Considerations in Counselling Clients with Disabilities

Specific issues are likely to arise in counselling clients with disabilities around sexuality, and these issues may require special consideration. It is important to note, however, that of arguably greatest importance is to consider the depth and breadth of the impact of sexual oppression on the client's life. In her memoir about her work as a sexual surrogate, Cohen-Greene (2012) shared the story of man with a disability who is deeply emotionally affected by social and sexual isolation. Cohen-Greene noted that this man's shame and guilt seemed related to his lack of opportunity to discuss his sexuality:

His parents never talked about sex and he received no education about it from the rafts of doctors and therapists who treated him throughout his life. Like many disabled people, Mark's sexuality went unacknowledged. Most people seemed to assume his disability canceled out his need for touch and intimacy (p. 4).

The effectiveness of counselling is related in part to factors that are unique to each client. Understanding the impact of oppression on a client's life allows the counsellor to use interventions and resources that are the best fit for the client and the factors that are impacting their lives. Understanding the full picture of the experience of a client with a disability takes time and flexible counselling style.

It has long since been understood that the factors that impact counselling outcomes for clients with disabilities are complex, as highlighted by Ayers and Duguay (1969):

The emotional problems, level of intellectual functioning, personality characteristics (motivation, self-concept, and temperament), communication factors, learning ability, parental influences, and environmental factors are critical variables that necessitate consideration in counseling the mentally retarded.

Regardless of the particular theoretical counseling technique or mode of therapy employed, all of these variables directly and indirectly influence the overall adjustment of the retarded. Hence, it is imperative that counselors become aware of them (p. 50).

For people with disabilities, a variety of limitations can impact the way that counselling is provided and the outcomes that are expected as a result of counselling. However, it is necessary to note that some common strengths associated with disability will positively

contribute to counselling outcomes, such as a tendency to follow ideas to conclusion (Wolfensberger, 1988), a tendency towards concrete thinking (Levitas & Gilson, 2000), and a good sense of humour (Paredes, 2008). Specifically exploring individual client's strengths and personal resources, and utilizing those strengths in counselling, is a key part of achieving counselling outcomes (Tallman & Bohart, 1999). In the end, the most commonly cited factors that impact counselling outcomes, independent of ability, are the quality of the working alliance and the existence of an external support structure (Parker, 2012). An understanding of a client's daily life, support system, and his or her experiences as a person with a disability will allow counsellors to develop a strong working alliance with clients, and possibly to engage with important people in the client's life outside of counselling.

How disability impacts therapeutic work. A person's disability can impact many areas of his or her life, from who they relate to, the opportunities available to them, and the access they have to resources. This impact is related to two factors: 1) limitations in functioning skills and abilities as a result of the disability, including low IQ, difficulty controlling personal behaviour, high incidence of other mental health concerns, and dependence on others for support; and 2) having a disability impacts the life experiences and opportunities available to the person, their control over their life, and their individuality. For many people with disabilities, limitations in their ability to learn and integrate the new information they glean from counselling could impact the overall effectiveness of counselling (Benson, 2004; Mansell & Sobsey, 2001), although it has been argued that clients with disabilities are also rarely offered all possible therapeutic options (Mohr, 2007). As a result, it may be necessary for counsellors to adapt the

interventions and techniques they use with clients to ensure that they are understandable, relatable, and provide benefits to clients. For example, although several clients that I see may have similar presenting issues, their varying abilities with language means that the interventions that I use with each of them, and the amount of time it takes to learn a new idea, varies tremendously. Recognition of personal differences and flexibility in the delivery of counselling services is necessary to practice effectively and to see positive outcomes for clients (Ivey & Leppaluoto, 1975).

Although it is necessary to adapt much of the therapeutic techniques we use with clients who have disabilities, it is also necessary to recognize how a client's disability shapes the way their actions are interpreted by both their support network and their professional supports (Lovett, 1985). In his seminal work regarding the counselling needs of those with cognitive impairments, Lovett argued that counsellors and support workers typically focus on a client's behaviour and work to adjust behaviour that is deemed undesirable. Alternatively, Lovett (1985) suggested that "rather than focusing on a specific problem behavior...[use] the way persons act as the best clue of how they feel they have been treated" (p. 20). Simply, for individuals whose communication skills are not strong, the way that they respond to situations provides evidence of their internal experiences, areas of concern, and their overall mental health. Despite the potential need for counselling techniques to be adapted for clients with cognitive impairments, efforts to increase awareness and knowledge surrounding sexuality should be age-appropriate and focused on healthy sexual expression, rather than being based only on an individual's level of physical and cognitive functioning (Chivers & Mathieson, 2000; Katz & Lazcano-Ponce, 2008; Low & Zubir, 2000).

Language and interpretation. For some clients with disabilities, limitations will be primarily physical. For many clients, however, cognitive limitations can impact the effectiveness of counselling (Benson, 2004). Studies on the efficacy of group therapy for anger management found that client outcomes were impacted by receptive vocabulary (Rose, Loftus, Flint, & Carey, 2005) and verbal IQ (Willner, Jones, Tams, & Green, 2002). Determining whether clients can understand and apply the information gained within counselling is an ongoing effort between the counsellor, the client, and the client's support network.

Clients who attend counselling often have a staff member or support person present at meetings to allow the client to be understood by the counsellor. For some clients, having another person present, particularly one who shares much of the client's life experiences with them, is a way for the client to relate what has occurred for them to the counsellor. It is also an opportunity for staff to learn how to work with the client on their counselling goals. For other clients, the presence of an interpreter can be a hindrance to the burgeoning working alliance. In my observations and experience of therapeutic work with clients who have disabilities, it seems that staff presence in counselling sessions can have benefits to clients. For example, clients who have difficulty communicating may benefit from having a person in attendance who can interpret what they share with their counsellor. It is also beneficial for counsellors to see the patterns of interaction that the client engages in regularly, as evidenced by how they interact with a person who attends their counselling sessions with them. Finally, support workers and family members are rich resources of information about concerns or issues

that are impacting clients, some of which a client may not be able to speak to independently.

A caveat of relying on the assistance of staff to interpret what a client wishes to say is that the information that a counsellor receives from staff is likely to be biased by staff perceptions of the client's problems. The conceptualization of the concerns that affect clients with disabilities could be impacted by staff perception of the meaning or intent behind behavior (Lovett, 1985). Given that the goals of counselling are different than the goals of daily support, staff members have a vested interest in the reduction of behaviour that is deemed inappropriate or undesirable due to the specific agency policies that guide their daily work with clients, and safety is often considered first priority. When working with clients who wish to, or need to, have a support person in sessions with them, counsellors should make every effort to glean information from the client herself, and should consider the client's best interests in choosing interventions or in facilitating the identification of goals for counselling, rather than the desires of the support person.

Cultural considerations. For people with disabilities, many aspects of life can be impacted by disability, including social relationships, access to, and involvement in activities, community events, and education or employment, and the kind of support that is provided by counsellors, physicians, and other support professionals. As such, having a disability impacts the cultural milieu of clients, and is arguably a cultural identity itself. Counselling clients with disabilities regarding sexuality further requires counsellors to explore culture as it relates to disability, sexual identity, sexual mores and values, and the intersection between these facets of cultural identity. Working with clients with

disabilities requires an understanding of the experience of disability, but also of the impact of cultural variance on the way that sexuality-related issues impact clients' experiences and goals in therapy. For example, a client who devoutly follows a religion in which sexual activity prior to marriage is discouraged will have a potentially different set of concerns and will come to counselling with a different understanding of their own sexuality than a client who does not follow a religion with these views. Similarly, cultural traditions surrounding sexuality should also be explored and carefully considered by counsellors working with clients.

For several decades, research has illuminated the importance of counselling from a multicultural perspective in achieving positive client outcomes, creating a positive counselling experience for clients, and encouraging client self-determination (Burn, 1992; Katz, 1985). For example, Burn argued that counsellors develop personal philosophies and biased beliefs about the cultures of clients, and this impacts client welfare, self-determination, and autonomy. Similarly, Katz (1985) found that counsellors who work from a monocultural perspective are less effective than counsellors who work from a culturally-sensitive perspective. It is important to clarify that multicultural counselling is not simply the exploration of multicultural issues that may be impacting client experience, but involves exploring how multicultural issues impact the therapeutic relationship, and acknowledging the intersection between culture and various forms of discrimination (Sue, 2001).

In order to effectively practice from a multicultural perspective, several competencies are required (Sue & Sue, 1999), including awareness of one's own values, biases, and assumptions, developing an understanding of the worldview of clients, and

understanding how cultural difference might inform the counselling interventions and approaches that are the most effective and appropriate for clients. Increasing self-awareness requires counsellors to consider how dominant cultural values inform personal beliefs, and to consider alternative beliefs or values, which can be achieved by asking specific questions of oneself, such as “what values, beliefs, opinions and attitudes do I hold that are consistent with the dominant culture? Which are inconsistent? How did I learn these?” It is also important to consider nonverbal communication, as actions such as eye contact, touching, or seating arrangements have cultural implications.

Ethical considerations. Ethical concerns impact the practice of all counsellors, but there are particular ethical concerns that require specific attention in order to ethically provide counselling to clients with disabilities. Consider the ethical implications that may be involved when a client and their guardian attend an initial counselling session. In my experience, many of these meetings involve the guardian or family member identifying the issues that they feel the client needs counselling to resolve, and the client doesn't always agree with this assessment. Whether that client is motivated to attend counselling or whether that client understands her rights as a client is usually not clear until several sessions in, once a relationship has begun to form. As counsellors, we need to be particularly cautious that we are acting in the best interests of our client, not his or her families, the agencies that support him or her, or the government bodies that fund the services he or she receives.

Ethical considerations are impacted by whether a client is legally dependent on a guardian for decision-making assistance or not. In the case that a client has participated in a capacity assessment and has been deemed legally dependent regarding medical

decisions, the consent of a legal guardian must be obtained (Applebaum, 2007; Guess, Benson, & Seigel-Causey, 2008). However, regardless of legal guardianship status, best practice for all counsellors is to make every effort to obtain the understanding and consent of clients themselves. Most individuals with disabilities will be able to effectively engage in the informed consent process, either independently or with support (Horner-Johnson, & Bailey, 2013). Individuals that are not legally supported to make decisions still require careful consideration that exploitation and coercion are not impacting their choice to engage in counselling which can be mitigated by encouraging clients to seek the advice of trusted supports, such as family members (Dalton & McVilly, 2004).

The presence of a guardian or other person with a level of power over clients can limit an individual's ability to fully engage in counselling (Raffensperger, 2009). As such, privacy and confidentiality are particularly important issues to consider as a counsellor. Confidentiality is a careful balance between protecting the privacy of clients and maintaining a strong working alliance, and the right of a legal guardian to determine the activities that a client may engage in, and information regarding the outcomes of treatment, including counselling (Evans, 2009; Gomez-Taylor, 2012). Some counsellors manage this balance by inviting legal guardians to engage in conversations about the importance of client privacy prior to counselling commencing, and committing to provide general progress updates and information on the general themes that arise in counselling.

In order to effectively work with people who have disabilities around sexuality concerns, and to minimize the risk of potential harm to clients, counsellors are ethically obligated to increase their competence to work with people who have disabilities

(Hertzprung & Dobson, 2000). Considering that sexuality is a normal component of adolescent and adult life for people with and without disabilities, gaining competence in working with sexuality-related concerns is an ethical decision for counsellors. Prior to working with clients who have disabilities, it is necessary for counsellors to examine their own biases and beliefs regarding disability and sexuality. For example, counsellors whose understanding of disability is based in the medical model were reported as having less beneficial counsellor-client relationships, particularly when counsellors viewed the client's disability as the most important factor of that individual's identity (Parkinson, 2006). Alternatively, training counsellors to see individuals with disabilities as people with equal rights, responsibilities, and goals had benefits on counsellor practice. It has long since been understood that graduate-level counsellor education should incorporate training on understanding diversity in ability and other factors (Harris-Bluestone, Stokes & Kuba, 1996), although counsellor education typically does not include training in disability or sexuality issues (Weiss et al., 2010). Education regarding these issues is reliant on attentive professional development that increases knowledge and skills that are necessary for effectively working with clients who have disabilities is necessary (Post et al., 2007), as well as professional development opportunities that address conservative, limiting attitudes (Brantlinger, 1983; Booth et al., 2003; Fronek, et al., 2011; Murray, MacDonald, & Minnes, 1995; Murray & Minnes, 1994).

Counsellors who engage in self-reflection on their personal biases can mitigate the risk that prejudiced beliefs can lead to the use of inappropriate interventions, the misdiagnosis of presenting problems, or exacerbation of the client's problems (Darley & Gross, 1983). In particular, it is necessary for counsellors to be aware of the tendency for

limiting assumptions that often arise in counselling clients with disabilities. For example, counsellors should be cautious not to make assumptions about the importance of issues that are unrelated to the client's disability, or to place too high importance on issues related to the client's disability. Similarly, counsellors should be careful not to assume that problems in their client's life are the result of the disability. Counsellors should be aware of whether they have lower expectations for the capability of clients with disabilities to change.

Environmental factors that impact counselling. Therapy exists as part of a client's overall environment (Cottis & O'Driscoll, 2009), and may need to be adapted due to environmental constraints that impact a client's ability to engage in counselling. For example, issues relating to income will impact a client's ability to attend counselling, particularly if counselling fees are not subsidized (Mirfin-Veitch, 2003), and difficulties with transportation may impact the accessibility of counselling (Royal College of Psychiatrists, 2004, p. 40). Environmental factors and life stressors are associated with an increased risk for mental health issues in people with disabilities (Hastings et al., 2004), and well-being has been found to be associated with opportunities to make choices, comfort and attractiveness of one's residence, and involvement with family (Heller et al., 2002). Outcomes of therapy are also impacted by environmental factors, including access to external supports (Willner & Hatton, 2006). Specifically, home life has been identified as a major influence on counselling outcomes, especially factors related to personal safety and the stability of important relationships (Parker, 2012).

Supporting clients who have disabilities to explore sexuality-related concerns in counselling requires a consideration for the impact that the client's disability has on his or

her daily life, relationships, and experience of sexuality. Counsellors should also consider how language and cultural community impacts and is impacted by clients' experiences. Further, counsellors working with clients who have disabilities may need to consider ethical implications related to guardianship, competence, and self-awareness of personal biases and beliefs.

Practical Applications for Counselling Clients who have Disabilities

A variety of methods designed to work with clients who have disabilities and present various sexuality-related concerns have been described in the current research. Issues related to sexual abuse, sexual offending, fetishes and paraphilias have been established, and a variety of psychological methods have been suggested, including group psychoeducation, cognitive-behavioural therapy, and social skills training. In this section, I will describe some of the primary sexuality-related issues that might arise in counselling, review some of the possible therapeutic techniques and approaches that counsellors can use with clients who have disabilities, and to provide some resources that may be of assistance to counsellors working with this population.

Common sexuality-related concerns. Counsellors who work with people who have disabilities could encounter a variety of concerns related to sexuality, including: masturbation; exploration of sexual orientation and identity; self-esteem and attractiveness to potential partners; past or current sexual abuse or trauma; concerns regarding the availability of potential partners; the development of skills necessary to negotiate a sexual or romantic relationship; sexual dysfunction due to physical ability or medication effects; issues related to transitional periods, such as from childhood to adolescence, or from adolescence to adulthood; issues arising from inappropriate or

illegal sexual activity; and issues relating to parenthood. Some of these issues will be explored in more depth in the following sections.

Physical needs. Due to limited access to romantic or sexual partners, people with disabilities often use masturbation as their primary sexual outlet (Ludlow, 1991), as well as a means to cope with boredom and restrictions in their living environment. Although masturbation is a normal and healthy sexual activity, engagement in masturbation is often seen as a behaviour of concern by service providers, support workers, and families, potentially due to inappropriate or excessive masturbation (Gomez, 2012). Masturbation is a normal, healthy part of human sexuality (Hillman, 1975), unless it becomes an activity that impairs functioning or puts others at risk (e.g., in cases of public masturbation; DeVuyst & McCulloch, 2006). Counsellors may find that clients bring forward issues of shame or guilt related to masturbation, or have experienced some negative effect due to their masturbation (e.g., legal issues).

Sexual orientation and identity. Pervasive myths about asexuality arguably limit the opportunity that people with disabilities have to engage in exploration of their sexual interests, and stigma around same-sex sexual behaviour further limits the likelihood that people with disabilities have examined or explored these issues effectively (Swango-Wilson, 2008; Cuskelly & Gilmore, 2007; Yool, Langdon, & Garner, 2003). When it comes to working with clients who have disabilities around sexual orientation, it is imperative that counsellors have a strong understanding of the history of counselling related to sexual orientation, of their personal beliefs regarding sexual orientation and identity, and the client's understanding of their sexual orientation. Although little work is available regarding counselling LGBT clients with disabilities, Davies' (1996) book, *Pink*

therapy: A guide for counsellors and therapists working with lesbian, gay and bisexual clients, provides extensive information on therapeutic work with lesbian, gay, and bisexual clients, and provides an extensive overview of the history of therapy aimed at this group.

Sexual abuse and trauma. People with disabilities are at high risk for being sexually abused or coerced (Baladerian, 1991). Vulnerability to sexual abuse is affected by a variety of factors, including limited ability to recognize and manage risky situations, limited self-empowerment skills, a need to be liked or wanted, a strong desire for friends and intimate relationships that has been unmet, social expectations to conform to people in positions of authority, and past sexual abuse (Hickson et al., 2013).

Counselling clients with disabilities around sexual abuse issues can involve working through past sexual trauma, establishing skills for protecting oneself from sexual abuse and reporting sexual abuse that has occurred, and establishing what constitutes sexual abuse or inappropriate sexual behaviour. Allen and Borgen (1994) proposed a unique, multimodal curriculum for a 10 week psychoeducational group for survivors of sexual abuse who have developmental disabilities. The outline of the curriculum included establishing a working alliance, acknowledgement and acceptance of the abuse, recounting the abuse, breaking down feelings of isolation and feelings associated with stigma, as well as labeling and expressing these feelings, resolving issues of personal responsibility and survival issues related to sexual abuse, grieving the loss of the pre-abuse identity, cognitive restructuring of distorted beliefs and stress responses, self-determination and expressing feelings; and sexual education and skill building. This curriculum highlights the necessary issues that need to be addressed with clients who

have experienced sexual abuse. Clients who have disabilities and have experienced sexual abuse benefited from the development of a group that explored issues related to sexual abuse and disability, encapsulating a broad range of issues. Counsellors who facilitate the exploration of sexual abuse trauma with clients should carefully consider how clients are impacted by sexual abuse, and how that experience intersects with the client's experience of disability.

Developing romantic relationships. Social isolation and loneliness are important issues that face many people with disabilities. As discussed previously, people with disabilities are especially limited in their ability to find romantic partners due to societal taboos on the sexual attractiveness of people who have disabilities. As a result, much of the sexuality education that does exist for people with disabilities is focused primarily on biological functioning, and neglects to cover issues such as developing romantic social skills, successful romantic relationships, and the emotional aspects of sexual intimacy. Chivers and Mathieson (2000) reported that sexual education for people with disabilities was focused primarily on issues related to safety from sexual abuse. These authors argued that the focus on biological functioning, without the exploration of emotional aspects of sexuality, silences conversations around intimacy, desire, and pleasure. In turn, isolation is reinforced. Interestingly, Chivers and Mathieson also reported that people with disabilities themselves most requested information regarding how to meet potential romantic partners, and how to interact with those partners. Fortunately, for many clients that I have worked with, it appears that some progress towards open sex education has been made. Several agencies that provide daily supports to people with

disabilities also provide sexual education workshops and resources, and there are social dances and events held to allow people the opportunity to socialize with their peers.

Establishing a strong working alliance. The therapeutic relationship, or working alliance, between a client and counsellor is of utmost importance in providing effective counselling and achieving outcomes. For many clients with disabilities, the aspects of a strong therapeutic relationship are novel experiences. It may be that they have never had someone listen to what they want to say, or that someone has never listened without judging or correcting them. It may be that they have never been told they have the right to decline to speak, or to ask questions about what they're told. Counsellors should take care to avoid reinforcing the limiting, prejudicial experiences clients with disabilities may face. The therapeutic relationship provides an opportunity for counsellors to introduce new ways of communicating and interacting.

Although many clients who have disabilities are subject to authoritarian relationships between themselves and professionals who provide the services they require, Lovett (1985) identified the importance of establishing a collaborative relationship with clients who have disabilities, as these relationships increase self-determination, and therefore increase success in achieving counselling goals:

I think that the relationship between the person helping and the person helped is often a critical variable. I think it is more than just 'playing with words' to say that when we 'treat' a person, we are putting ourselves in a relationship that is very different (and for me, less desirable) than when we work with a person on a challenging situation. (p. 33)

Furthermore, Strauser, Lustig, & Donnell (2004) reported that for many clients with disabilities, the relationship with their counsellor is one of the most important parts of them reaching their counselling goals.

Societal views of disability create a power differential between clients who have disabilities, and the counsellors who work with them. For counsellors to be effective in developing collaborative, effective, therapeutic relationships with clients who have disabilities, counsellors need to become adept at analyzing their own power (i.e., personal privilege based on race, gender, ability status, sexual orientation, or age) and how they contribute to power dynamics through their behaviour, assumptions, and interactions (McWhirter, 1998).. Consider how your experiences with freedom have shaped who you are and how you view the world, and consider how you would view the world if you did not have those same freedoms. Consider how a client who has a disability might view you if you do not have a visible disability yourself.

Brechin and Swain (1988) established six principles of practice, based on the perspectives of clients, for a strong working alliance: (1) to be an entitlement rather than an imposition; (2) to promote self-realisation rather than compliance; (3) to open up choices rather than replace one option with another; (4) to develop opportunities, relationships, and patterns of living in line with their individual wishes rather than societal expectations; (5) to enhance their decision-making control of their own lives; and (6) to allow them to move at their own pace (p. 224). What these principles highlight is that for counselling to be effective with clients who have disabilities, counsellors need to be focused on the needs, wants, and dreams of their clients, rather than on the goals of parents, guardians, support staff, or agencies.

Developing meaningful goals. For many people with disabilities, it is assumed that any emotional or psychological problems they have are the result of their disability. However, Oliver (1995) noted that emotional and psychological concerns arise most often from a lack of control over physical and social environments that many people with disabilities experience. Counsellors who work with clients with disabilities reported that the goals of counselling a client with a disability should include the facilitation of self-empowerment in practical, emotional, and social life areas. McWhirter (1998) identified the importance of empowerment in the counselling relationship, particularly for clients who are subject to prejudice and discrimination in their lives. McWhirter provided five required components of empowering counselling: (1) collaboration, in which both the client and counsellor are actively involved in the development of goals and in the counselling process; (2) competence, in which counsellors recognize and utilize the natural resources and abilities of the clients to facilitate change; (3) context, which is an acknowledgement of the forces that impact the experiences of the client both in- and out-of counselling; (4) critical consciousness, which is the ongoing facilitation of client awareness of their own context; and (5) community, which impacts the client's ability to use the skills they learn in counselling to create lasting change.

Adaptations in counselling. Regardless of therapeutic approach, adaptations to therapeutic work have been suggested by several researchers (e.g., Gallagher, 2002; Mansell, 2002; Whitehouse, Tudway, Look, & Kroese, 2006). Taken together, it is apparent that one of the most important adaptations in therapy with clients who have developmental disabilities is typically the speed at which the counsellor moves through the counselling process. For clients who have difficulty interpreting or using verbal

language, communication between the client and counsellor needs to be slowed to allow clients the necessary time to fully process information. Counsellors may also need to be flexible about the length of sessions (e.g., shorter duration), frequency of session (e.g., more frequent), and location of sessions (e.g., home visits may be required). Although adaptations may be required, Gallagher (2002) aptly noted that "...all people (especially children, the elderly, the less educated, non-English speakers, and those with mental illness or disabilities) understand more than they are able to communicate or demonstrate" (p. 209). Regardless of the specific adaptations that may be required, counsellors should take care to be flexible and willing to adapt the approaches that they use with clients.

Possible Therapeutic Approaches

A variety of therapeutic approaches have been found to be effective in working with clients who have disabilities, although some interventions require adaptations to make them more understandable or effective (Mansell, 2002; Parker, 2012). Given that higher rates of psychological disturbance are reported for people with disabilities than without disabilities (Dune, 2012), effective psychotherapeutic services are crucial for the wellbeing of this population. However, many psychological theories and styles are not easily adapted for work with individuals who have cognitive impairments. Although modifications for therapy are possible, attitudes regarding the effectiveness of therapy for people with disabilities has stagnated work in this area. For example, Bender (1993) reported that clinicians typically view working with people with disabilities through a lens of pessimism, in which they conceive that their efforts will be less fruitful with clients who have disabilities. Despite this pessimism, an ever-growing body of research

exists on what therapeutic approaches are most effective in work with people who have disabilities, including cognitive-behavioural therapy, person-centered therapy, and solution-focused therapy. For the purposes of this manual, we will summarize the research in these areas, with specific focus on solution-focused therapy.

Behavioural interventions. The primary focus of counselling clients who have disabilities has commonly been behavior modification, typically for the purpose of protecting staff and clients in institutional or supportive living settings, where some actions may pose a significant risk to others or difficulty in daily functioning. Additionally, behavioural interventions may be popular in part because they do not require the consent or agreement of the individual (Lovett, 1985). As such, it is relatively simple for a counsellor to provide behavioural support to a client on behalf of service providers or family members, rather than with the specific intention of meeting clients' goals. Given that funding for counselling is sometimes provided by external agencies (e.g., Persons with Developmental Disabilities, in Alberta), measurable outcomes are required components of ongoing funding. Approaches such as cognitive-behavioural therapy may be related to behavioural outcomes, and therefore be a possible choice for clinicians.

Cognitive-behavioural therapy (CBT) focuses on the interaction between thoughts, emotions, and behaviour, specifically focusing on changing maladaptive behaviour that results from faulty thinking. Although CBT has been found to be an effective approach for clients with disabilities, the collaborative component between client and counsellor is often missing, particularly in identifying goals for therapy (Stenfert Kroese, Dagnan, & Loumidis, 1997). Some argue that clients with cognitive

disabilities may not be able to fully engage in CBT, in part due to concerns that self-reported thoughts and behaviours may be inaccurate, although strong agreement between client self-reports and staff reports has been found (Voelker et al., 1990).

Person-Centered Therapy. Rogers (1951) presented humanist or person-centered therapy in the 1950s, as an alternative method to psychoanalytic approaches. Person-centered therapy (PCT) places the client-counsellor relationship as the most important aspect of therapy, and considers this relationship as the foundation for client change. PCT focuses on the client's strengths and experiences, and is arguably adaptable to be used with any client (Hurley, Tomasulo, & Pfadt, 1998). For people with disabilities, the person-centered therapeutic relationship may be a novel experience that allows the client an opportunity for emotional expression that is fairly rare (Demanchick, Cochran, & Cochran, 2003). Involvement in decision-making and goal-setting could be very empowering for many people with disabilities, especially those who receive significant support in decision-making (Duchan & Black, 2001).

Although PCT is beneficial for clients with disabilities, and form the basis for a strong therapeutic relationship, there is less structure in using this approach with clients. Given time constraints that are often present when counselling is funded by government agencies, short-term counselling is served well by a focused approach. Government-funded counselling also needs to focus on measurable outcomes in order to maintain funding. Using solution-focused therapy approaches, with person-centered skills for developing a therapeutic relationship, provides a balance between the needs of the client and the restrictions that may be present on the length of counselling.

Solution-focused therapy. Solution-focused therapy (SFT) is a postmodern therapeutic approach that views people as being capable of resolving their own problems, and that places client strengths and resilience at the forefront of counselling (DeJong, 2002, Selekman, 1997). Counsellors collaborate with clients to identify strengths and the tools they are already using, and then apply those strengths and tools to manage emotional distress that occurs in regular life, carefully avoiding pathologizing clients or their experiences (Greene, Lee, Trask, & Rheinscheld, 2005). SFT assumes that: (1) every client is unique, and therefore their solutions will be unique; (2) clients have strengths and an inherent ability to help themselves; (3) no situation is fully negative; (4) counsellors do not label client's behaviour as positive or negative, but simply aim to interact in a way that allows the client to use a new response that creates a more adaptive pattern; (5) counsellors cannot change clients, but clients can change themselves; (6) although SFT is relatively brief in comparison to long-term approaches (e.g., psychodynamic), SFT can and should be a process that occurs slowly and at the pace of the client; (7) cause and effect is not acknowledged, because problems are seen as unpredictable events; (8) solutions are of greater focus in counselling than problems, and solutions are not necessarily connected to problems; (9) emotions are a component of every problem and solution, and affect the language the client uses to interpret problems and solutions; (10) change is inevitable and continual, and build upon previous changes; and (11) the focus should be on the future rather than the past, as clients cannot change their past (Lipchik, 2011).

Given that many people with disabilities experience a life in which their limitations are at the forefront of attention, SFT is an empowering approach that focuses

on unique personal strengths rather on the limitations that result from one's disability. The empowerment of this approach is in sending the message to the client that they do not need to be "fixed" but that they are already equipped with what they need to resolve their problems (Greene et al., 2005). Regardless cultural, health, or personal factors such as intelligence, SFT uses positive framing to explore strengths and exceptions to problems (Lipchik, 2011).

Several aspects of SFT are potentially beneficial with clients who have disabilities. First, this theory recognizes that people who have disabilities, like everyone else, have a unique set of skills and barriers that impact their ability to change. Second, by viewing problems as current life situations, those problems are not attached to clients as personal failings, aspects of their disability, or the fault of an external person, and it focuses the goals of therapy on those things that clients can currently control. Finally, through the exploration of exceptions and a focus on personal strengths, the ideal outcome of SFT is that of action. Combined, SFT brings together the positive aspects of person-centered approaches (i.e., a collaborative working alliance in which the client is in control) and CBT (i.e., challenging defeating thoughts translates into changes in behaviour).

SFT has also been found to be an effective approach for the treatment of sexual disorders. Trepper, Treyger, Yalowitz, and Ford (2010) argued that SFT is consistent with the typically sex-positive stance that counsellors who deal with sexuality issues have. What other models view as resistance is framed as natural, realistic caution or as an error on the part of the counsellor. Specifically, applying SFT to sexual problems requires that counsellors recognize clients have "...sexual experiences that need to be

learned about, nurtured, and encouraged. They believe that the client has the capacity to understand the multiple dynamics that might play into the maintenance of sexual problems” (Trepper, et al., 2010, p. 39-40). Unlike other approaches to sexuality counselling, SFT uses questions as the primary communication tool, with the aim of focusing on exceptions to problems and previous solutions.

Tools and Strategies

Pre-session change. Used in the first session, this intervention begins the process of focusing on solutions and exceptions to problems, rather than problems themselves (Trepper, et al., 2010). The counsellor asks the client to notice changes that have occurred since the client made the appointment to attend counselling. If the client responds that they have experienced no change, the counsellor can proceed with having the client describe what he or she has been doing to prevent his or her problem from worsening. If the client responds that things have improved since he or she booked his or her counselling appointment, the counsellor uses those changes as a springboard for identifying client strengths and goals for counselling.

Miracle question. This popular SFT intervention is typically used with clients who are struggling to set goals or who have not connected a feeling with behaviours (de Shazer et al., 2007). The counsellor explores with the client how things in their life would change if they suddenly experienced a miracle. My example of the miracle question is: *Imagine that you went to sleep, and while you were sleeping a miracle happened. This miracle is that your problem is solved. When you wake up in the morning you do not know that the miracle happened. What is the first thing you would notice that was different? What would someone else notice about you that is different?*

Upon asking the miracle question, the client and counsellor would explore what internal resources the client has that could help facilitate change.

Scaling. Scaling is a simple intervention that involves having the client rate his or her problem, experience, or solution on a scale from 0 to 10 (Trepper, et al., 2010). Responses to this question are used as the starting point from which to talk about how the client experiences the problem, and also as a means for regularly monitoring how the client experiences the problem. Comparing ratings over time is also a way to encourage the client and focus on the improvements he or she has made in managing his or her problem.

“How” questions. SFT counsellors focus on asking “how” questions rather than “why” questions (de Shazer et al., 2007). “How” questions focuses discussion around specific actions and successes that the client has had, rather than on the purpose of those actions. For example, a counsellor might ask “how were you able to talk to your partner about your concerns with the frequency of sex?”

Compliments. Compliments are commonly used in SFT as a way to reiterate the message that clients are the experts on their own lives, and to acknowledge incremental growth. SFT counsellors use compliments that focus specifically on client change and strengths, and typically repeat the client’s own language about the changes he or she has made (Trepper, et al., 2010).

In addition to the SFT interventions described above, a fair number of interventions and techniques from other therapies are potentially appropriate for use with clients who have disabilities. For example, Gillan (1980) proposed that counsellors could

engage in social skills training with their clients, either individually or in a group, to help them develop the necessary skills to negotiate sexual and intimate relationships.

Sexuality counselling is often approached from a multimodal, integrated approach. Many possible interventions that can be used to explore sexuality issues correspond with Lazarus' (1981) seven modalities of multimodal therapy. For example, to examine the cognitive modality, counsellors can utilize interventions that aim to examine cognitive patterns and distortions and develop positive self-affirmations. The affective processes modality can be explored using journaling or other writing, as well as reviewing various kinds of emotions that could be involved in sexuality. Sensation interventions include relaxation techniques and somatosensory training that allows clients to develop an awareness of the connection between their body and emotions. The interpersonal modality can be explored through various forms of role-play or rehearsal, as well as assertiveness and social skills training. Interventions that are related to behavioural rehearsal, thought-stopping, and social reinforcement can be used to target behavioural modalities. Narrative exercises, guided meditative imagery, and the use of art are excellent tools for exploring imagery. Finally, the biological modality can be explored through sexuality education, and exploration of health risks and benefits, and working towards making healthy sexual choices.

Counselling clients with disabilities regarding sexuality could include interventions and tools that are drawn from sex therapy as well, including sexual permission training, communication training, assertiveness training, couples counselling, non-demand pleasuring, physical awareness, sensuality exercises, and exploration of past traumatic or negative events related to sexuality (Leiblum & Wiegel, 2002).

As reviewed in this section, a variety of possible interventions and strategies may be useful in exploring sexuality-related issues with clients who have disabilities. Many more interventions may be valuable in exploring these issues, although some interventions may require adaptations for use with some clients, particularly those with challenges related to writing, reading, or communication.

Additional Resources

As issues related to disability and sexuality gain more awareness among professionals and community members, a variety of useful resources are available for counsellors looking to gain more understanding of the experiences of people with disabilities. A selection of resources has been provided below.

Films and Videos: Some documentaries have been made recently that explore issues related to disability and sexuality:

- *(Sex)abled: Disability Uncensored* (2009) is a 15-minute documentary that features a discussion panel regarding disability and sexuality issues. This video can be viewed at the following web address:
<http://healthequity.sfsu.edu/doc/title/sexabled>
- *Scarlet Road* (2011) is a documentary that follows a sex worker who works with people who have disabilities. This video can be viewed at screenings that are listed on the film website: <http://www.scarletroad.com.au/about/>
- *Uncharted Territories: An Exploration of Disability and Sexuality* is a documentary that explores sexuality and disability through interviews with a variety of individuals. This video is available from *Vimeo* at
<http://vimeo.com/42847406>

- TED Bangalore has made a video of a speech about disability and sexuality by Rupsa Mallik available on their *YouTube* channel
(<https://www.youtube.com/watch?v=6Qk95L0AkPI>)
- The Kinsey Institute released a video of Dr. Lofgren-Martenson speaking about her research about sexuality and adolescents with disabilities. The video is available at <https://www.youtube.com/watch?v=FMLQPuyaht0>
- The University of California's television department released a documentary providing information for the development of education that prevents sexual abuse and supports healthy sexual expression for people with disabilities. This video is available on *YouTube* at
<https://www.youtube.com/watch?v=dJJ4RSfchYo>
- For an interesting interview with the founder of *Sexability.org*, Dr. Rafe Eric Biggs, follow this link: <https://www.youtube.com/watch?v=EzezpKF6Aw4>

Books: Several books regarding disability and sexuality are available that include useful information for both clients and professionals.

- *Sexuality and Learning Disability* (Fanstone & Katrak, 2003), is a good resource for those who support people with disabilities.
- *The Ultimate Guide to Sex and Disability* (Kaufman, Silverberg, & Odette, 2007) is an excellent resource for clients with disabilities, and is written by people with disabilities themselves.
- *Holding On, Letting Go* (Drury, Hutchinson, & Wright, 2000) is a resource for parents and families of people with disabilities.

- *Exile & Pride: Disability, Queerness, and Liberation* (Clare, 1999) provides an extensive look at disability, class, sexual abuse, and sexual minority, based on her personal experiences and current research.
- A very personal discourse regarding female sexuality and disability is provided in Willmuth and Holcolmb's (1994) book *Women with Disabilities: Found voices*.
- For a variety of essays from varying perspectives, McRuer and Mollow's *Sex & Disability* (2012) explores important issues.
- A great resource for working with clients who have suffered sexual abuse is Maltz's (2012) *Sexual Healing Journey: A Guide for Survivors of Sexual Abuse*.
- Although not current, Cornelius' (1982) handbook, *Who Cares?* for counsellors working with clients with disabilities is a rich resource.
- For a thorough exploration of considerations that counsellors should be aware of when working with clients who have disabilities around sexuality, see Craft's (1994) *Practice Issues in Sexuality and Disabilities*.

Websites: Several self-activist informative websites exist for people with disabilities to gain sexual knowledge and resources. These websites are also a useful source of information for counsellors.

- *SexualityandDisability.org* (<http://www.sexualityanddisability.org/>) provides information on exploring one's body, developing relationships, engaging in sexual activity, pregnancy and parenting, as well as sexual violence.

- *Naked Brain Ink* is an entertaining blog written by a woman with autism, who explores sex, love, and relationships (<http://nakedbrainink.com/3636/include-sexuality-education-asd/>).
- *Disabled World* includes essays on a variety of topics that affect people with disabilities, including sexuality (<http://www.disabled-world.com/disability/sexuality/>)
- *MyHandicap* is a website with extensive information on sexuality issues related to disability, including LGBT issues, sexual education, prostitution, and issues related to supportive work (<http://www.myhandicap.com/sexuality-disability-disabled.html>)
- *Shameless Magazine* includes features regarding sexuality and disability (<http://shamelessmag.com/blog/entry/storying-disabled-womens-sexual-and-intimate-lives>)
- Check *Sexability* for information about myths and stereotypes, a blog, and webinars for learning more about these issues (<http://sexability.org/>)
- *SelfAdvocateNet* includes specific discussions around disability and sexuality (<http://selfadvocatenet.com/disability-and-sexuality/>)
- See *The Sexualization Report* for an interesting essay on sexuality and disability (<https://thesexualizationreport.wordpress.com/section-1-sexuality/sexuality-and-disability/>)
- Ontario's *Sexuality and Access Project* lists workshops and training opportunities and information regarding sexuality and disability (<http://sexuality-and-access.com/>)

- The British Columbia Coalition of People with Disabilities created a list of additional resources, available on their website (http://www.disabilityalliancebc.org/docs/sex_disabilitywebliog.pdf)
- Sexuality Education Counselling and Consultancy Agency (SECCA) provides information and training regarding disability and sexuality (<http://secca.org.au/>) in Australia.
- The Canadian Federation for Sexual Health provides limited information and links to other information on their *Sexuality and Disability* website (http://www.cfsh.ca/your_sexual_health/sexuality-and-disability/)
- The Rose Centre provides up-to-date news information on issues related to sex and disability (<http://therosecentre.ca/>)
- The Calgary Sexual Health Centre provides a listing of educational tools, workshops, and services focused on disability and sexuality (<http://www.calgarysexualhealth.ca/programs-workshops/people-developmental-disabilities/>)
- Planned Parenthood created a curriculum for teaching adults with developmental disabilities about sexuality and sexual health, which can be ordered through their website (<http://www.plannedparenthood.org/planned-parenthood-northern-new-england/local-education-training/development-disabilites-sexuality>)
- The Sexuality Education Resource Centre MB website has some information on sexuality and disability (<http://www.serc.mb.ca/sexuality-relationships/sexuality-and-disabilities>)

- The Independent Living Institute includes a library of essays and information relevant to people with disabilities, including information regarding sexuality (<http://www.independentliving.org/docs5/sexuality.html>)
- Information for anyone teaching sexual education to youth who have cognitive disabilities can be found at *SexualityandU.ca* (<http://www.sexualityandu.ca/teachers/teaching-sex-ed-for-youth-with-intellectual-disabilities>) or in this handout from *TeachingSexualHealth.ca* (<http://teachers.teachingsexualhealth.ca/wp-content/uploads/Sexual-and-Development-Disability-Guide-2013.pdf>)

Summary

It is likely that at some point in their career, counsellors will work with an individual who has a disability, whether that disability be visible or not. Counselling clients with disabilities requires flexibility, adaptability, and a willingness to question ones' own perceptions of ability. In order to work effectively with clients who have disabilities, counsellors need to have a deep understanding of how disability impacts one's life, particularly their social and romantic life, how their personal privilege affects their relationship with their client, and how they can work to minimize the damage of the oppression that these clients have faced. It is clear that self-reflection of our personal biases about disability will allow greater counselling relationships to form, and will lead to greater outcomes for clients. People with disabilities are often silenced by those around them, prevented from fully engaging in all of life's opportunities due to their disabilities. Counsellors have a unique ability to explore these experiences with clients in a therapeutic way.

There are several take-away messages from this manual that counsellors can bring with them into work with their clients. First, it is imperative that counsellors are able to be flexible in how they provide counselling to their clients, and what tools or interventions they use. Reviewing handouts and tools to ensure they are written in clear, plain language is a good first step to ensuring psychoeducational materials are accessible to all clients. Second, counsellors who work with people with disabilities will likely be working with families, guardians, and support workers as well. No matter how many other people are involved in a client's support, however, it is the clients themselves that are the focal point of counselling, and it is the client's needs that should be the primary concern of counsellors. Third, many different therapeutic approaches and interventions could be potentially valuable in work with clients who have disabilities. In this manual, I suggest that solution-focused therapy might be an effective method for approaching sexuality-related concerns with clients who have disabilities, because this approach is focused on strengths, can be brief if necessary, and is easily adaptable to a client's skills and abilities. For counsellors who are interested in taking this approach, further reading on solution-focused therapy will be helpful. The final take-away message, and perhaps most important message, is that people who have disabilities have unique life experiences and stories that deserve to be heard and recognized. As counsellors, we can hear these stories and advocate for our clients in very special ways, and can have an important impact on our client's lives.

Chapter 5: Conclusion

This final project compiled current research surrounding disability, sexuality, and counselling outcomes, and presented a manual to be used by counsellors who are working with a client who has a disability, or who wish to develop competence in working with clients who have disabilities. In the manual portion of this final project, I explored some of the major issues that impact people with disabilities around their sexuality, as well as how these issues affect counselling methods that can be used. The primary purpose of this manual is to enable counsellors to have the knowledge and tools necessary to work with people with disabilities that are experiencing sexuality-related concerns. The manual explores current and historical issues that affect many people who have disabilities, including myths and stereotypes, common sexuality-related issues that arise for people with disabilities, adaptations to counselling that may be required, as well as possible therapeutic approaches to working through sexuality issues with this population. In this section, I will explore possible directions for future research, as well as provide a reflection of my experiences in compiling this final project.

Directions for future research

For nearly four decades, a growing body of research has been developed around disability and sexuality, as well as around counselling clients with disabilities. Still, the research available on this subject is limited, and ongoing research is required to fully understand the issues that people with disabilities face regarding their sexuality, and their specific counselling needs. After reviewing the current literature surrounding counselling, disability, and sexuality, I have identified several areas in which further

research would be beneficial. First, ongoing research around the specific professional development needs of counsellors working with people who have disabilities would be necessary to determine the impact of this training on counselling outcomes. Although it is clear that increased education for counsellors serves to increase their competence in working with this population, there is a lack of research that explores expected improvements in outcomes as a result of this professional development.

Second, research on specific interventions and strategies that can be used to enhance the learning of clients who have disabilities is limited. Interventions or therapeutic methods that are specific to working through sexuality issues are scarce in the literature, as are specific guidelines for adapting counselling interventions for clients who have disabilities.

Third, there is little research on the effectiveness of group therapy for clients who have disabilities. Psychoeducational groups that explore sexuality do exist for clients with disabilities, although peer-reviewed curricula for these groups is not available, and outcomes from group therapy have not been reported. Several agencies provide group sexual education in the Calgary area, and the Calgary Sexual Health Centre offers training to agencies and support workers regarding sexuality and disability. Disability service agencies may also provide ongoing workshops for clients around healthy relationships, sexual safety, and personal boundaries. Further research into the effectiveness of these groups and workshops is needed to understand the impact that attendance at these groups and workshops will have for clients.

Reflection

For several years, I have worked in support roles that serve people who have developmental disabilities. During this time, I have had the opportunity to interact with many people, and have had the honour of hearing their stories. It has been these relationships that has guided my interest in counselling clients who have disabilities. They were people who have experienced an extraordinary amount of hardship in their lives, from living in restrictive institutions, to experiencing abuse and bullying as a result of their disabilities. They all experienced extreme loneliness, and many of them shared issues of low self-esteem and feelings of shame. It wasn't their stories that led me to want to work with them as a counsellor; rather, it was their resilience.

I became aware of the issues surrounding sexuality and disability through my work. Several of the clients I worked with shared their experiences of seeking counselling (or being involuntarily brought to counselling) regarding issues related to sexual behaviour, identity, and interests. However, few of these experiences were identified as helpful, and many of these experiences seemed to actually be harmful. Counsellors were holding the same false, prejudicial beliefs about disability and sexuality, and their clients were suffering as a result. It is important to note that it is unlikely that any of these counsellors were maliciously causing harm to their clients. Rather, these counsellors were likely unaware of the complex issues surrounding disability, sexuality, and romantic relationships for their clients. These counsellors were lacking self-awareness around their own biases and values. As a result, I began to explore my own personal biases and beliefs.

Completing this final project has been a learning experience on many levels for me. Beyond the academic learning, I have developed a greater sense of the political and societal issues that impact people with disabilities every day. I have had the opportunity to explore these issues from many lenses, including people with disabilities, their parents and families, disability service agencies, and the overall community. Most importantly, I've had the opportunity to view these issues through my own lens. The outcome has been a greatly increased sensitivity to the issues that impact this population, and a greater understanding of how counsellors help these clients create change in their lives.

Of course, completing this project altered my understanding of disability and sexuality in surprising ways. I admit that prior to writing this project, my understanding of disability and sexuality included many of the prejudicial stereotypes that can so drastically harm clients. This project has served as a means for me to acknowledge and challenge these biases, ultimately making me a stronger counsellor. I also experienced an altering of my understanding of sexuality; going in to this project, I viewed sexuality primarily through a personal lens and an academic lens, neither of which were flexible. Learning of the myriad of ways that sexuality impacts lives, from one's self-esteem to one's health, I came to understand sexuality as a topic that encompasses personal, political, spiritual, cultural, physical, psychological, and economic areas. I've learned that when I explore these issues with future clients, with or without disabilities, I will need to explore all of the facets that shape someone's sexuality and their experience of their sexuality.

Going forward in my career as a counsellor, I hope to use what I have learned to inform the approaches that I use with clients and the exploration I do about the issues that

affect their lives, and to continually reflect on how my own biases and assumptions impact how I work. I am motivated to see client's problems as part of a larger picture of who they are, and to avoid generalizing the needs of my clients based on what I assume is affecting them. Overall, I am grateful to have embarked on this journey, as it has undoubtedly change me on both a professional and personal level.

Hopes and Goals for this Project

Going in to the writing of this manual, I had a few simple goals for how this manual would be used. Primarily, my goal was to simply bring to light an issue that I've seen affect so many people with disabilities, and to provide counsellors with the knowledge they needed to address this issue in counselling. It is my sincere hope that the counsellors who read this manual will have the opportunity to question their own attitudes and beliefs about disability and sexuality, and that they will gain a deeper understanding of the lived experience of people with disabilities. It was also my goal that counsellors could use the information I've gathered in this manual to inform the decisions they make in counselling, particularly regarding sexuality, and that they would learn some of the tools they could use to do this successfully. Ideally, counsellors who read this manual will have a foundation from which to approach issues of disability and sexuality, and will have gained some confidence in approaching these topics.

After writing this final project, I can see that this manual may serve in other important ways. It is my goal that the information that is provided in this manual will be made available to professionals who work with people who disabilities everyday, and that they will be inspired to support clients to explore their sexuality in healthy, meaningful ways. I hope that this manual serves to highlight the need for extensive learning

opportunities for people with disabilities around sexuality, romantic relationships, and sexual health. In Calgary, some agencies already provide some training to clients and families about disability and sexuality, and I hope that this manual sparks further development of these programs. An increase in access to these programs would not only benefit clients, but would also benefit families and agencies supporting clients with sexuality-related issues. Approaching these topics openly may reduce behavioural issues and the vulnerability of clients with disabilities, thereby reducing costly investigations and interventions.

Perhaps most importantly, it is my goal that this manual will benefit people who have disabilities. Through contribution to the growing discussion of sexuality and disability, I hope that this manual will encourage a greater voice for people with disabilities around their sexuality and sexual needs. It is my goal that clients who have disabilities will receive counselling services from counsellors who are better informed about disability and sexuality, and who are confident and nonjudgemental about these issues.

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