The (Physically) Wounded Healer: The Impact of a Physical Disability on Training and Development as a Counselling Psychologist: A Case Study

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Abstract

This case study investigates how physical disability might impact on the therapeutic training and development of a counselling psychologist. Discourse analysis of extracts and quotations from the author's own reflexive journal reveals some potential implications of a subtly discriminatory environment that perpetuates societal negativity towards the physically disabled. A limited level of understanding of the experience of physical disability amongst peers/colleagues is seen as a potential issue for the profession to address as an ethical obligation for ambassadors of social justice, possibly through specific disability training and reflexive practice. The archetype of the 'wounded healer' in the helping professions is an affirmative perspective by which to view physical disability in training. The physically disabled trainee is encouraged to commit to personal reflexive work to develop his/her understanding of the various possible implications of their physicality on relationships, be they personal or professional. This can ultimately prove the experience of physical disability to be a useful tool which, when used skillfully, has the capacity to increase relational depth in therapeutic relationships.

Keywords: physical disability, counselling psychology, reflexivity, training, discourse analysis, Foucault

The intention of this paper is to use my own personal experience to investigate the impact of physical disability on training in a Professional Doctorate in Counselling Psychology in the UK. It will begin to address the marginalization of issues of physical disability within counselling psychology, which has led to a dearth of literature addressing the impact of physical disability on trainees, be they disabled or otherwise. There is an ethical obligation for all counselling psychologists, be they trainees or qualified practitioners, to embrace issues of inequality and discrimination in practice and research (British Association for Counselling and Psychotherapy [BACP], 2015; British Psychological Society [BPS], 2009) in order to be "knowledgeable about the diverse life experiences of the clients (we) work with" (BPS, 2013, p. 7), and challenge inequitable economic, political and social practice. In order to uphold such principles, all practitioners must have a reflexive awareness of their own attitudes towards others, as well as the social contexts that might affect client's experience. Any institutional lack of awareness of the needs and experiences of individuals with physical disabilities whilst training in the profession allows for negative attitudes and stereotypes pervading society to subtly permeate the training environment, and therefore to continue on to negatively affect service provision and therapeutic relationships. It also places extra demands on the physically disabled trainee to negotiate their way through an environment that could be experienced as alienating and subtly oppressive, despite being one that purports to define itself by its ability to be self-aware and accepting of all. Throughout, I shall use the terms 'physical disability' and 'disabled' as de-

scriptive terms, whilst simultaneously acknowledging that much of the disabling aspect stems from societal attitude, rather than purely as the result of physical impairment (Oliver & Barnes, 2012). I also use the terms in recognition of the potential for individuals to identify with disability as an empowering group culture arising from a common experience of oppression (Eisenhauer, 2007; Swain & French, 2008).

Jung (1963) introduced the phrase 'wounded healer' to promote the use of personal experience of woundedness/healing to enhance therapists' empathic feeling towards clients, or, through countertransference, to notice something meaningful happening within the therapeutic relationship. In this paper I use the phrase in a more literal sense in order to raise awareness of issues of disability and discrimination as fundamental to counselling psychology's social justice approach to theory and practice, which recognizes 'all contexts that might affect a client's experience' (BPS, 2013), including social contexts and the potential effects of power differences, inequality and discrimination between groups in society (Winter, Guo, Hanley, & Wilk, 2016). The title also reflects my understanding of the therapeutic relationship as at the heart of counselling psychology. Whilst personal experience of physical disability within therapeutic practice is not the primary focus of this paper, it is acknowledged that if deeply embedded constructions of disability are not addressed and challenged in therapeutic training, there is a risk that incorrect assumptions of disability (from either the therapist or client perspective) could negatively affect the therapeutic relationship. Conversely, if sufficiently recognised and understood, the use of feelings evoked by the presence of physical disability in the relationship (again, either those of the therapist or client) can provide unique opportunity for positive therapeutic work.

A discourse analysis of extracts and quotations taken from my personal reflexive journal is presented, using the work of Foucault as an epistemological standpoint from which to examine sociocultural power relations. Alongside a review of current literature concerning disability, society and therapeutic training, a brief mention of the work of Foucault in relation to disability precedes an outline of the methodological approach adopted. A significant portion of the paper then discusses the analysis and findings, before outlining implications arising from the research to bring the study to conclusion.

Disability, Society and Foucault

As a concept, disability is ambiguous and is understood from numerous epistemological perspectives that advocate conflicting social and political attitudes (Olkin, 2012; Smart & Smart, 2006; Swain & French, 2000). Historically, Western society does not look well upon physical disability, having viewed it primarily as an incurable, and therefore tragic, individual medical issue for nearly two centuries (Gilson & Depoy, 2000; Lancet, 2009; Wilder, 2011). In a capitalist society, the economic consequences of a physical disability have reduced people to either work-based or needs-based subjects (Stone, 1984), whilst the current popular cultural demands for physical 'perfection' and absolute independence are often unobtainable for individuals with a physical disability. Thus, physically disabled people in contemporary UK society are subtly but comprehensively branded as biologically inferior and unattractive, socially devalued (and, worse, expensive), and generally disempowered (Shakespeare, 1993).

Common to all discourses of physical disability is the issue of power inequalities. Foucault (1926-1984), whilst not dealing specifically with physical disability, focused on analyses of power relations between institutions and the body in his later writing (e.g. Foucault, 1982), with particular attention paid to the way bio-power, as a dominant discourse, objectivises the individual (as sick/healthy, normal/abnormal) in order to subjectify those who do

not conform to the institutionally defined norm. This has the effect of establishing a power imbalance whereby the 'subject' is at the mercy of the dominant 'other', be it an institution or an individual. For those who experience their body as reconstructed within a medical discourse, their existence thus becomes restricted by the subordination this imposes upon them as 'disabled' (Sullivan, 2005).

Challenging the medical perspective of physical disability, and attempting to reclaim some sense of power (Oliver & Barnes, 2012), the social model of disability (e.g. Oliver, 1996) focuses on the subtle but significant difference between physical impairment and disability (Shakespeare, 1993). According to this model, 'impairment' refers to an individual's specific physical limitations, whilst 'disability' is the consequence of a society that does not cater its environment to impairment, and thus itself becomes the disabling restriction inhibiting personal choice and autonomy. Viewed through this lens, disability becomes an issue of oppression and diversity to be addressed by empowerment through collective identity, rather than one of individual responsibility and devaluation (Oliver & Barnes, 2012; Olkin, 2012).

Counselling Psychology, Therapeutic Training and Disability

Disabled people have historically been at the edge of awareness as a client group for counsellors, despite physical disability being as fundamental a part of human existence as birth and death (Reeve, 2000a). Consequently, disability literature for both counsellors and counselling psychologists is sparse, and the psychological needs of the physically disabled population are often misrepresented as one-dimensional issues of grief and/or depression (Abberley, 1987). Within the discipline of psychology, physical disability doesn't fare much better, tending to be reduced to pathological issues of loss and denial (Parkinson, 2006; Reeve, 2000a, 2004). It has been asserted (and broadly accepted) that disability is not merely a physical issue, but also one of embedded societal oppression at an institutional level, and it is perhaps for this reason that there are so few disabled counsellors, psychologists and researchers (Oliver, 1996; Oliver & Barnes, 2012). Indeed, the few positive perspectives in informative literature that challenge the medical model originate from authors who themselves have disabilities; for example, Corker (1999), Olkin (2012), Parkinson (2006), and Reeve (2002). Generally, however, the disability literature is not rich, and the narrative voice of the disabled person is not strong (Rosenberg, 2009).

The counselling psychologist is as susceptible to negative constructions and attitudes towards disability as any other human in society. They, unlike other members of society however, have a responsibility (and obligation) to "make themselves knowledgeable about the diverse life experiences of the clients they work with", and to be reflective about their practice (BPS, 2013). Regarding disability, this appears often to have been left unaddressed in counselling training (McLeod & Machin, 1998; Parkinson, 2006), and unconscious assumptions are often left unchallenged. The fundamental importance of a non-judgmental approach to counselling is widely acknowledged (Merry, 2002), and all therapists need to reflexively explore their own responses to disability. This is important for working with clients with physical disabilities, as negative labelling may well already be part of their experience (Lenny, 1993). There are many ways to understand issues of disability, and it is perhaps imperative that the counselling psychologist realizes the potential impact of the presence of disability on the therapeutic relationship. Conversely, it can also be seen to be of great benefit if the therapist is able to understand some of the social forces their client must manage and live with in their daily existence, whether through their own experience of physical disability, or through awareness training.

Negative societal attitudes regarding disability and oppression may detrimentally affect the physically disabled counselling psychologist trainee's own sense of confidence and self-worth. In order to function effectively, it has been suggested that only by embracing/anticipating issues of disability and creating a sense of agency within themselves, can the physically disabled therapist overcome some of the barriers they face (Levinson & Parritt, 2006). However, if the disabled individual has experienced much negativity/discrimination regarding their physical differences, it is possible that they may have developed a 'secondary handicap' (Sinason, 1992) that serves to provide a defence against experiences of hostility; the expression of emotion such as anger/frustration by physically disabled people is not well received as it runs contrary to expectations of 'grateful' behaviour stemming from the charity model of disability so often used in the media (Donnellan, 1982). Instead, an attitude of compliance and projected good humour can be subconsciously adopted in order to placate potential hostility and to counterbalance the potential for personal feelings of rejection stemming from being a problem/nuisance or demanding (Levinson & Parritt, 2006). Sinason (1992) also suggests that by exaggerating the effects of differences, the discriminated-against individual can feel they have some control over how they are perceived. However, this too can be seen as a secondary handicap, as the individual may be doing so in part to avoid dealing with what may be a painful acceptance of personal limitation. Whilst there are papers addressing issues of physical disability as practitioners (e.g. Levinson & Parritt, 2006; Oliver, 1995; Reeve, 2000b; Sinason, 1992), without acknowledgement and investigation of such issues in training, these mechanisms can work against the physically disabled therapist by maintaining a negative 'sub' positioning, both in terms of their career, and also perhaps more importantly, within the development of the therapeutic relationship. Currently, the experiences of physical disability in training is not forthcoming in the literature.

Past research has investigated the impact of counsellor multiculturalism competency on therapeutic practice (Fuertes et al., 2001); recognising the existence of multiple belief systems, and the need for therapists to be aware of the cultural and contextual environments of their clients. Many minority groups (such as those defined by race, gender or sexuality) are overcoming historic societal prejudice and are becoming increasingly demographically representative in counselling training in the UK (Watson, 2004). The result of their presence as part of the learning environment is that any negative attitudes/beliefs that trainees may hold (be they knowingly or otherwise), have the potential to be uncovered, challenged and worked through by individuals during the training process (Scaife, 2010). Disability can be (and has been) accepted as such a cultural identity, stemming from a common experience of societal oppression (Swain & French, 2000). However, the historic lack of presence of people with physical disabilities in psychological research and in counselling psychology, has led to a generalised unacceptable superficiality of (mis)understanding of the phenomenology of physical disability. If the impact of the presence of physical disability on the therapeutic relationship is dealt with purely theoretically by the able-bodied community without the consultation with and involvement of disabled people themselves, there is a risk of it remaining discriminatory and negatively simplistic.

Addressing this point, Chaudhuri (1999) agrees that personal contact with a disabled therapist can indeed provoke anxiety and fears of mortality in clients that may negatively affect the therapeutic relationship. However, he also illustrates how this same stimulation of negative/difficult feelings in clients as a response to the presence of the therapist's physical disability can provide opportunity for meaningful therapeutic work, assuming the therapist has good knowledge and understanding of the potential impact of the presence of disability on the therapeutic relationship. Despite being potentially pivotal to the therapeutic relationship, attitudes towards the presence of physical disability in therapy are not as likely to be recognised or addressed in training as other historically discriminated against groups, as even logistical issues of accessibility to training venues have

played their part in preventing physically disabled people from accessing and being present in counsellor train-ing in the past (Halacre, 2011; White, 2011). This perhaps illustrates the depth and level of acceptance of insti-tutional discrimination.

Methodology

All work undertaken was carried out following the ethical guidelines and principles set out by the BPS (2009) and Health and Care Professions Council (HCPC, 2016). Ethical approval for the study was obtained from the University Research Ethics Committee.

As a female first year counselling psychology trainee with a degree of acquired physical disability in the form of mobility impairment and chronic pain resulting from a spinal cord injury, I have used selected extracts retrieved from my private reflexive journal as material to be analysed. A recommended activity as part of my doctoral training, journaling in this case, has consisted of a process of personal reflection undertaken throughout the course at moments during which I have wanted to explore any personal experience of strong emotion. As such, I believe it to be an individual perspective that is a relevant and candid source of data for the purpose of this study, as I discuss further below. For analysis, I have chosen four key moments/exchanges that particularly in-duced reflexive thought as examples of challenges resulting directly from the presence of physical disability, and that have particular implications for the counselling psychologist, be they disabled or able-bodied. I have used these quotations to structure the analysis as title headings for different discourses, mirroring their use as title headings for journal entries.

To enable the exploration of complex interventions and relationships both personally and institutionally, a quali-tative case study methodology was employed. All investigations are situated from an embodied location, and thus, knowledge can only be socially situated. Standpoint theory, as an epistemological approach, challenges dominant discourses by supporting the notion that the privileged partial perspective of the marginalized individual can aid a more objective view of social and political power (Harding, 2004). Paying attention to the subjec-tive experience of the marginalized few can reveal new truths of social and political disadvantage. By identifying the embedded power constructs of social institutions that maintain the experience of oppression in the lives of individuals, analyses/critiques of these relations between power and knowledge can help bring about change to create more just societies (Harding, 1993). These notions sit well with the philosophy of counselling psychology as a profession that prides itself on valuing the individual subjective and intersubjective experience of the world (Strawbridge & Woolfe, 2014), whilst simultaneously addressing issues of social justice and diversity (BPS, 2013). A social constructionist approach to reality that acknowledges human creation of meaning derives from residing in both the subjective and the objective (Crabtree & Miller, 1992). It is, perhaps, this context-dependent closeness of the case study to real-life situations that is its greatest contribution to learning. Whilst it is recog-nised that the results of a case study can be criticized as not generalizable in the traditional sense, it can also be strongly argued that findings can be meaningfully related to other, similar contexts (Flyvbjerg, 2016). Conse-quently, the case study serves to provide a valuable alternative perspective from which to learn about complex phenomena.

A Foucauldian epistemology, primarily concerned with the broader cultural systems of meaning that establish power relationships in society, culture and institutions, also informed the choice of methodology. Discourse

analysis was chosen to investigate the formulation of meanings that create cultural 'truths' and underpin everyday thoughts/action (Parker, 1992) as it deciphers how these social realities are both created and sustained (Burr, 1995; Hacking, 2001). From this position, truth and reality are viewed as subjective concepts that are restricted by, and entrenched in, their sociocultural and historical context (Burr, 1995). In this vein, language, as the combined understanding of rationalizing of human experience (Leeds-Hurwitz, 2009), is analysed in order to expose these essential systems through which communication of beliefs and notions of reality are constructed (Hacking, 2001).

The process of analysis of the current data was informed by guidelines set out by Willig (2003, 2012), and consisted of an interactive cyclical engagement and scrutiny of the text, each time focusing in more detail on particular aspects of the discourse, whilst all the while referring back to the Foucauldian concerns of sociocultural power relationships. The analysis focuses on identifying the dynamic ability of specific discourses to construct and morally position both speaker and object, and thus, load them with expectation, assumptions and the unequal distributions of power, entitlement and responsibility.

The issue of subjectivity in analysing one's own reflexive material is perhaps worthy of extra consideration in this particular case study. There can be no position of neutrality from which to approach a discourse analysis, and an analysis of one's own reflexive writing is even harder to detach from. It is important, therefore, to recognise that this paper is written purely from the perspective of one person, and does not claim to reflect the experience of all counselling psychologist trainees with a physical disability. Such analysis of quotations relating to physical disability that I clearly found confounding during training does, however, work to place an individual experience/understanding into a broader, sociocultural framework that is pertinent to all counselling psychology trainees in the UK.

Results

In this section I present four examples of responses I encountered and analyse them in relation to the assumptions and positions indicated for me as a disabled counselling psychology trainee.

The analysed text illustrates many examples of a moral discourse that appears to originate from the moral model of disability (Rosenberg, 2009). The effect of this sort of discourse was felt to be oppressive and, as such, typically evoked unvoiced anger across my reflexive journal. Whilst, of course, my personal response to such comments is relevant, this paper is primarily focussed on addressing issues of physical disability in training on a broader institutional and societal level. To reflect publicly on my own emotional responses risks a 'confessional' slant that I feel is unnecessary for this purpose. Instead, perhaps, it is more relevant to assert the importance of the role of personal therapy in training as the ideal (or even necessary) environment in which to explore how the felt effects of the social construction of disability might affect the self-construct of the disabled individual in order for it not to impinge negatively on the therapeutic relationship. On this matter, it is also pertinent to note that other trainees with a physical disability will have their own subjective responses to the effects of (c)overt disablism, which may vary significantly to those I present. I have not, to date, found any similar studies with which to situate this one in relation to. Perhaps this fact itself illustrates something about the positioning of physical disability as an issue to be addressed in training.

"Don't Make a Fuss; Walking Is Good for You"

The above quote was noted on the first day of the course during an icebreaking exercise that involved walking and was in response to my sigh at the idea of having to walk further than I felt was comfortable/manageable. To "make a fuss" suggests that I had unnecessarily or unreasonably complained; it is a dismissive response that seems to make no attempt at even feigning to understand the situation for the less able-bodied. It tacitly, but firmly, suggests that any problem expressed/felt by the disabled individual is either exaggerated or non-existent, and thus, has the effect of denying both felt experience and needs. It also has the effect of firmly locating any issue within the individual, rather than as something for everyone to consider.

Mobility/movement further becomes loaded with moral value in the phrase "walking is good for you". It is stated as unquestionable 'truth', although is no more than an opinion; walking is not always beneficial and may even sometimes be harmful for some individuals. This statement serves to deny such a perspective, and further suggests that it is a matter of merely adopting a different (better/superior?) attitude akin to stoicism; movement, thus, becomes linked to virtue and happiness. This is potentially an extremely destructive association for the individual struggling to balance mobility needs with restrictions imposed by pain, as it potentially brings into play personal issues of worth, ability and value which, in turn, become directly linked to effort and mind-set. There is also a degree of belittling and infantilization in the comment as it sounds like (and was felt to be) a reprimand. The implied message is clear; 'don't trouble me/us with your little problem – you must change your bad attitude and try harder…then you will be worth more'.

As a counselling psychologist trainee receiving this message, there is a further moral consideration to this; how to respond? Due to my interest in disability as a psychological, sociological, philosophical and political issue, an awareness of the moral model of disability facilitated an understanding of the situation as societal rather than personal. I, nonetheless, felt keenly the force of personal oppression and dismissal, and a moral anger (directed at myself) is expressed in the text at my inability to use my voice in challenge, instead submitting to power and constructed positioning;

> "I wish I'd done what I know needs to be done and say that I felt I had been 'told off'. For all the disabled people with even less of a voice than mine feels, I should have been able to question him."

In this instance, I felt it had become a moral matter as a disabled trainee who has received such a message to attempt to address it within the discipline as a matter of social justice: It is within the HCPC 'Standards of Conduct, Performance and Ethics' to challenge discrimination (HCPC, 2016, p. 5), and the BPS 'Code of Ethics and Conduct' to respect individual, cultural and role differences (BPS, 2009, p. 10), as well as to reflect on established principles, values and standards (p. 15). The desire to educate colleagues was, perhaps, also an attempt to minimise my own feeling of having been marginalised.

"Do You Consider Yourself to Have a Disability?"

Unsurprisingly, a medical and political (welfare state) discourse permeates and informs the analysed text. I struggled with and mused over the above question (posed on the university enrolment form) for many days prior to the Professional Doctorate course beginning. Without being aware at that time of any specific theories of disability and oppression, the corresponding data in the reflexive journal is littered with suspicion around this question:

> "Who is asking if I have a disability? And why? What will the implications be…should I just say no and manage? I feel somehow it would be safer."

It is significant that this question is asked by an institution. The medical model of disability has informed establishments since the 1800s (Lancet, 2009), asserting that the body is both the subject of medical study and subject to medical and para-medical power. Viewing it this way, the current welfare state locates disability as having both positive and negative components, based on a scale of need rather than productivity. Practically, this translates into the disabled individual being the recipient of certain rights and 'privileges' to aid their living which come at a significant cost of potential loss of autonomy/independence and privacy. An example of this (which most certainly informed my suspicion of the above question) is the current system of Personal Independence Payment (PIP) assessment whereby to qualify for any financial assistance with living and mobility, the disabled individual must first surrender their entire private life to the scrutiny of the State via an extensive and invasive questionnaire, before attending an assessment to determine if what the individual claims is plausible (potentially incorporating an element of 'guilty until proven innocent'). The stigma of 'scrounging' infuses this process, and any benefit felt by being awarded such a benefit is potentially offset by feelings of failure, loss and diminution.

Assuming that the majority of individuals who identify themselves as having a disability in the UK will have at some point gone through this (or some similar bureaucratic) process, the suspicion at the illustrated question in the analysed text highlights its potential to threaten the disabled student in a similar way, this time in an educational environment. The question then becomes one about what purpose it has, who it actually serves, and what repercussions may be felt. If, as is so often the case in society, to 'declare' oneself as disabled is to segregate oneself from the majority in order to receive a degree of practical assistance, the onus is on the individual to balance their individual benefit of practical assistance against the potential loss of autonomy (power), and even a perception of humiliation. For some, this is a case of absolute necessity, but in this instance, I identified myself in the text as having "passing rights to the able-bodied world", and thus, the possibility of "hiding" my disability in order to remain part of the (more powerful) majority. There is tension for the individual even in this process of identification, as it constitutes an impossible split between the desire to occupy the position of the oppressor (by becoming the same in being different to those who are different), whilst maintaining an awareness of the reality of also being the devalued Other (Fanon, 1967). The strength of the felt effect of this perpetual mismatch of power is evidenced in my eventual choice to "manage", to take on the responsibility of potentially enduring levels of physical hardship that are not necessary, but also should not potentially cost a level of submission (surrender?) to the institution. The matter at this point becomes a personal issue, as well as an institutional one. In order to guard against the potential development of any 'secondary handicap' (Sinason, 1992), I felt it necessary to turn to personal therapy to explore my responses. For me to be able to reframe the personal experience of physical disability as wounded-ness/healing in order for it to be used to enhance empathic feeling towards clients in the therapeutic relationship, I too needed to experience healing from such potential challenge to self-worth/confidence.

The concept of disability itself was also challenged in the text in response to this question;

> "Do I consider myself to have a disability? Not when it comes to thinking I don't…but if I have to walk far or use stairs, I really do."

Here, the assumption of disability as a static, constant state is revealed to be simplistic and insufficient, rendering the question even more unanswerable. Adopting the perspective of the social model of disability (Oliver & Barnes, 2012), it can also be seen to illustrate the situational dependence of the question and the potential for the environment to be the disabling factor, rather than the individual's impairment. If the social environment is accessible and considerate of issues of physical limitation, then the individual with mobility difficulties is not disabled. This notion is further illustrated by my recorded musings on the bins in the disabled toilets at the university:

> "What would I do if I couldn't use my feet again? How on earth would I be expected to lift the lid of the sanitary/incontinence bins if they are operated only by foot pedals?"

Again, the disabling factor is the design of the bin and the lack of thought in its placement. It constructs the person who cannot use their feet to be the element that is 'wrong', and the issue becomes one for the individual to negotiate alone; potentially contributing to a feeling of a solitary and marginalised everyday existence. For the counselling psychologist trainee who is focussed on issues of disability and social justice, from both a personal and professional perspective this becomes another factor to consider in the debate over when, where, and how best to address raising awareness of the subtle forces of oppression that permeate everyday life for physically disabled individuals. I also increasingly feel that I personally have an ethical responsibility, according to the BPS Code of Ethics and Conduct (2009), to address these issues on behalf of those affected who may not be aware of it, or those who do not have the belief in the potential power of their voice of challenge.

"I Don't Consider You to Be Disabled"

The tragedy model of disability (Oliver, 1996) is thought to arise from the fear that some form of physical disability can (and through ageing, usually does) affect any/everyone. This fear is linked to a fundamental death anxiety present in all humans (Shakespeare, 1994; Wilson, 2003) that, consequently, interprets all physical disability to be an existential threat at some fundamental level. A natural reaction to fear involves rejection of that which triggers the emotion, and a denial of its existence. The above quotation from my journal was declared by one of my peers and was part of a friendly exchange about my mobility limitations that left me puzzled. The speaker had clearly intended her statement to be complimentary and reassuring, but instead I had felt disturbed by it;

> "Why not? I am, and it is significant to me – it affects my every minute. Does that mean I'm exaggerating my physical reality and my perceptions are wrong? Or does she mean that to her, to be disabled is a terrible thing and that she would treat me differently if she categorised me that way? Would she not be my friend?"

In this simple exchange, it was clearly felt that the speaker was revealing her belief that to be physically disabled was something so negative as to be almost unthinkable; wretched and to be pitied. She was adopting a curious (although sadly not uncommon, in my experience) position of authority in her statement that suggested that the social construction of the relationship between herself and the person with mobility difficulties (me) was a task for her (as the able-bodied individual?), and that she was bestowing the generous 'gift' of mercy, or looking the other way, to justify the existence of the friendship. In her denial of the existence of a physical disability and all the challenges that go with it (be they physical, social or otherwise), the speaker of the statement was also potentially silencing and invalidating my felt experience. The receipt of such (misguided) charitable benevolence from an able-bodied individual can negatively impact the self-esteem of the person with a disability

greatly; for no reason other than a physical inability, their validation, authority and worth as an equal human is threatened, or denied. From that point forward, I felt a need to hide/play down both my disability and also my felt experience in order to prove my worthiness of such charitable thinking, and not let friends/colleagues down by "succumbing to the truth of my physicality".

"That's not a Disability (Referring to the Restricted Mobility of my Left Leg), That's Life Experience"

The notion of the 'wounded healer' is likely to be familiar to most therapists and was first coined by Jung (1963) who intended the term to relate psychologically to the idea that there is great potential for compassion and relational understanding if the therapist has experienced suffering/pain/darkness for themselves and has worked through it to achieve a deeper understanding of life. Common to all humans and mortal experience are birth, death and pain (be it physical, psychological or both), and to recognise and understand the 'common sense' of being/feeling wounded potentially enables an equal and compassionate therapeutic relationship to develop. As such, the phrase has been lifted from traumatic discourse and set firmly and positively in the language of the 'helping professions' as illustration of a potential source of a certain wisdom and authenticity.

Despite the acknowledgement of the value of difficult personal experience, however, there appears to be a tendency within the therapeutic professions to be reluctant about disclosing such transient vulnerabilities, and instead privatise and gloss over them (Martin, 2011). Issues of practitioner disclosure are not united across theoretical approaches, or even agreed between individuals, and is too big a subject area to discuss in full here (see instead, Derlega et al., 1993; McLeod & McLeod, 2014). Suffice to say here, it is unclear whether the reluctance to disclose negative/difficult experiences/emotions is a result of society's apparent loading of moral worth to certain emotional states (e.g. the virtue hypothesis of happiness; Martin, 2007), or a professional feeling of "having to appear to be more than human; I must be perfect", in capability. Through such language in the analysed text, it can be seen that there is perhaps a danger in counselling psychology training for striving individuals to forget that one of the most important common factors in therapy is the experience and communication of humanness.

There are implications for professional practice that must be considered by the physically disabled counselling psychologist trainee when they begin working in placements. If social practices are inherently negative and discriminatory in relation to physical disability, it would seem likely that to encounter a disabled counsellor for the first time may challenge the client's perception of them as able and may even go so far as to suggest deficiency (i.e. extending the understanding of [dis]ability or [in]competence from a physical to professional one). How to handle this, alongside if, when and how to acknowledge their disability with clients, can only be a matter of personal preference (assuming that BPS and HCPC practice guidelines are followed at all times as base-line requirements), but is not necessarily easy to navigate. The quoted text below illustrates some of the potential for confusion on this:

> "Do you think I should broach the subject right when I first meet them? Or do you think I shouldn't say anything at all unless they ask? How much do I tell them if they do ask? After all, it's not about me, it's about them..."

The use of the word "broach" suggests that at this point, I was feeling that my disability was, again, a negative thing; something to be approached with caution and, therefore, something to be fearful of. This is surprising as I

deliberately chose to work in a hospital and with physical disability/sickness specifically because I feel I can relate to some of the many personal existential difficulties arising from such challenges to mortality, and to offer a deep understanding of the associated fears and prejudices that can feel so overwhelming. The quoted response from a colleague affected the author's perspective profoundly: "That's not a disability" challenges the idea that a physical restriction/limitation is something that automatically stigmatises an individual as one who is less able to function on all levels. This is, perhaps, an obvious notion to those who choose to think about it, but the prejudice and negative messages encountered on a daily basis are strong, and even the physically disabled individual who recognises the forces of oppression can be subject to them from time to time. "It's life experience" acts to reframe the visual physical difference as something with a history – a past that informs and produces knowledge and is therefore of value. It also implies that it is unique to the individual and, as such, imbues them with a capacity to access a profound knowledge that cannot be drawn upon by anyone else in the same way.

The relevance of personal therapy and supervision as necessary spaces to explore personal reactions arising from such questions is highlighted here as necessary for ethical practice (BPS, 2013; McLeod, 2007). Additionally, the personal on-going experience of challenging and reframing issues of disability in an empowering way that reaffirms a sense of agency, gives me, I believe, an everyday working understanding (and reminder) of some of the effects of oppression and sometimes hostile environments on individual lived experience and the internalised sense of self. For the disabled therapist, the one-time viewed *dis*-ability can thus itself become reframed as an *extra* ability; experience that can be acknowledged and drawn-upon to enhance awareness and empathic understanding of clients in therapeutic practice.

Discussion

Implications

In terms of enduring personal issues for the disabled individual in training, confusion, frustration, anger and a feeling of having to battle against institutional discrimination and implicit societal oppression appear to be common personal challenges in the analysed text. This is possibly reflective of many physically disabled individuals' experiences in daily living, and perhaps should not come as a surprise that it is recreated in a smaller learning community. It could be asserted that the defining humanistic value base and philosophy underpinning the profession of counselling psychology (Orlans & Van Scoyoc, 2008; Strawbridge & Woolfe, 2014) requires this particular group of people to endeavour to be fully accepting of all, and reflexive enough to be aware of their attitudes/responses to oppressed minorities (Tjeltveit, 2000). If, however, these attitudes are not brought to their attention, and the general negative stereotypes and prejudices produced and perpetuated by the society they reside in are not unpacked and scrutinised during training, then there is no opportunity for professional attitudes and encounters to mature enough to be able to provide an alternative environment for disabled trainees and, later, clients to experience (Scaife, 2010). The subtle yet essential difference noted between the comments "I don't consider you disabled" vs. "That's not a disability" illustrates the need for attention to such issues in training; the first phrase expresses a condescending and paternalistic exceptionalism reminiscent of the oppressive colonialist positioning of the Other (Fanon, 1967) which jars with the humanistic philosophy underpinning counselling psychology, whilst "that's not a disability" challenges both assumptions and perceptions of limitation in such a way as to open up possibility for empowerment and agency.

According to Cooper (2009), "an understanding of the client as a socially and relationally-embedded being, including an awareness that the client may be experiencing discrimination and prejudice" (p. 120) constitutes one of the six 'essential values' of counselling psychology for all practitioners, disabled or otherwise. The literature on values and ethics within the discipline appears to encourage counselling psychologists to actively engage in such critical thinking when examining their values in order to be ethically aware practitioners (McLeod, 2007). Yet, as with many issues surrounding disability, more education and awareness (for all concerned) is apparently essential for improvements to attitudes of equality. Disability training at an institutional level would go some way to address this, as could timetabled group reflexive activity, or, ideally, a combination of both. For the disabled trainee, it is perhaps responsibility enough to make sure that their own vulnerabilities/issues concerning disability are sufficiently addressed through individual learning/awareness, personal therapy and supervision. This then enables them to have the option of safely and ethically using their 'wounded' self effectively and helpfully in clinical practice.

Conclusion

In order to address the phenomenon of social discrimination encapsulated in the phrase 'difference and diversity', all counselling psychologists, as ambassadors of social justice, must seek to engage in developing knowledge and awareness of the experiences and challenges faced by marginalised groups of people, including those with physical disability.

It is also felt to be important for the disabled trainee counselling psychologist to carefully and thoroughly consider the impact of their disability on all their relationships, but perhaps particularly during their training. The above quoted phrases are representative of common attitudes towards disability throughout the UK and can be seen to have grown from the historic institutional constructions of disability, as well as embedded cultural representation, religious rhetoric and medical practice. It is my feeling that the large majority of society do not realise the level of discrimination and negativity directed at the physically disabled population, in part because it is so deeply ingrained to be discriminatory that it has become practically invisible, and certainly infrequently challenged on a personal level. Consequently, I feel that disability is an issue that must be reflexively addressed by all counselling psychologists in training, and that trainees with a physical disability must also personally address the matter from a particular perspective; we need endeavour not to be judgemental of the able-bodied individual who displays a subliminal ignorance of disability, whilst also taking care to challenge and understand both the origins and effects of discriminatory attitudes. Like all therapists, we also have a responsibility to be sure that our own personal impairments (of any sort) do not limit our ability to work with clients; it is an ethical responsibility to ensure that any vulnerabilities we may have concerning our own physical disability are comprehensively addressed.

For the disabled counselling psychologist who has worked hard on their own self-knowledge through personal therapy and clinical supervision and chooses to see their physical impairment through the lens of the affirmation model of disability (Cameron, 2008; Swain & French, 2000), the 'wounded healer' archetype may well resonate with their felt experience. In particular, the experience of an acquired physical disability can profoundly alter an individual's understanding of mortality, compassion and the 'human condition'; thus, becoming something to celebrate as a "rescue from superficiality" (Martin, 2011, p. 12), and an important facilitating factor in achieving depth in the therapeutic relationship. For this to happen however, the physically disabled trainee must ensure that they constantly reflect upon the impact of their disability on all relationships, whether social or profes-

sional, and that they understand their own potential sensitivities surrounding the issue, as well as the perceptions of others. Clearly, personal therapy in training is vital here, alongside ongoing supervision of practice. If such attention is paid to essential personal development, the counselling psychologist with a physical disability then has the opportunity to maintain and (healthily) protect their individual sense of worth, whilst simultaneously having opportunity to strive to transform their experiences into a useful personal resource for empathic awareness in the therapeutic relationship, as well as on a broader level for engendering change towards a more inclusive and just society.

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