

Guidelines for Assessment of and Intervention with Persons with Disabilities

Acknowledgements

These guidelines were developed by the APA Task Force on Guidelines for Assessment and Treatment of Persons with Disabilities¹. The task force members included Kurt F. Geisinger, PhD (University of Nebraska, Lincoln, Nebraska); Kay Kriegsman, PhD (independent practice, Bethesda, Maryland); Irene W. Leigh, PhD (Gallaudet University, Washington DC); Elina Manghi, PsyD (Adler School of Professional Psychology, University of Illinois at Chicago, Chicago, Illinois); Izabela Z. Schultz, PhD (University of British Columbia, Canada); Tom Seekins, PhD (University of Montana, Missoula, Montana); and Greg Taliaferro, PhD (Cincinnati Psychoanalytic Institute). Drs. Schultz and Taliaferro were the Task Force co-chairs.

The task force wishes to acknowledge Izabela Schultz, PhD for her foresight regarding the need for guidelines and for initiating their careful development. In addition, the task force is grateful to Rosemarie Alvaro, PhD, Thomas Bartlett, PsyD, Jim Butcher, PhD, Susan Drumheller, PhD, Michael Dunn, PhD, Stephen Flamer, PhD, Alan Goldberg, Psy.D, ABPP, JD, Virginia Gutman, PhD, Dara Hamilton, PhD, Roger Heller, PhD, Tamar Heller, PhD, Rosemary Hughes, PhD, William Kachman, PhD, Monica Kurylo, PhD, Kurt Metz, PhD, Sharon Nathan, PhD, Rhoda Olkin, PhD, Sara Palmer, PhD, Diana Pullin, JD, PhD, Jeff Rosen, PhD, Cheryl Shigaki, PhD, David Smith, PhD, Martha Thurlow, PhD, Michael Wehmeyer, PhD, Julie Williams, PsyD, and Gerry Young, PhD for their assistance in providing important feedback on several earlier drafts of the guidelines; to Diana Spas (University of Montana, Missoula, Montana) for her thorough and thoughtful review and editorial suggestions; to APA's governance groups who reviewed this document and provided valuable feedback and suggestions; and to the myriad other individuals for their careful review and comments. The task force also wishes to thank Anju Khubchandani, Director of APA's Office on Disability Issues, who assisted and provided counsel to the Task Force throughout this project, and to her administrative coordinators, Sara Laney and Mara Lunaria. Dr. Taliaferro wishes to thank the Research Fund of the Cincinnati Psychoanalytic Institute for its support.

The late Greg Taliaferro, PhD served as a member and co-chair of this task force. Greg made an indelible impression with not only his professionalism and determination, but his grace, his courage, and his puckish sense of humor. The Task Force dedicates this report to his memory.

1. At its February 2006 meeting, the APA's Council of Representatives approved the Task Force and allocated \$18,500 from 2006 discretionary funds. In 2007, the Council of Representatives allocated \$13,500 from its 2007 discretionary funds to support two additional Task Force meetings. No other group or individual contributed financial support, and no Task Force members or their sponsoring organizations will derive financial benefit from approval or implementation of these guidelines.

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Introduction

Approximately one in five Americans or roughly 50 million Americans are currently living with a disability (U.S. Department of Education, 2007). Individuals with disabilities and their advocates have worked for more than 40 years to eliminate attitudinal and physical barriers, to be fully included in all aspects of society, and to secure the freedom to choose their own futures (Jaeger & Bowman, 2005; Priestley, 2001; Switzer, 2008). Their efforts facilitated the passage of the Americans with Disabilities Act (ADA) of 1990. Nonetheless, many people with disabilities continue to encounter both blatant and subtle discrimination in employment, housing, education, recreation, childrearing, health care, and mental health services (e.g., Banks & Kaschak, 2003; Kirschbaum & Olkin, 2002; Raphael, 2006; Schriener, 2001; Smart, 2001; Stapleton, Burkhauser, & Houtenville, 2004; Waldrop & Stern, 2003; Woodcock, Rohan, & Campbell, 2007).

Although many persons who have disabilities have experienced discrimination, each individual reacts differently to those experiences. Moreover, each person assigns a unique meaning to disability, depending on the nature of impairment, the quality of social support and life demands (Olkin, 1999b; Olkin & Taliaferro, 2005; Vash & Crewe, 2004). Above and beyond their *disability* experiences, persons with disabilities have their own life experiences and, like everyone else, their own personal characteristics, histories, and life contexts.

To work effectively with people who have disabilities, psychologists need to become familiar with how disability influences a client's psychological well being and functioning. Psychologists should also become aware of how their own attitudes, reactions, conceptions of disability, and possible biases may affect their professional relationships with clients who have disabilities. Further, it is important for psychologists to learn the best "barrier-free" psychological practices for clients with disabilities, including provision of reasonable accommodations, and appropriate integration of disability-related issues into assessment and intervention.

Unfortunately, while psychologists receive extensive training in treating mental health disorders, they rarely receive adequate education or training in disability issues (Leigh, Corbett, Gutman, & Morere, 1996; Olkin & Pledger, 2003; Rubino, 2001; Strike, Skovholt, & Hummel, 2004). Few graduate psychology training programs offer disability coursework (Olkin, 2000; Olkin & Pledger, 2003). This paucity of training is a major barrier to providing effective services to clients with disabilities (Leigh, Powers, Vash, & Nettles, 2004; Olkin, 2002). Limited training and experience may leave many psychologists unprepared to provide clients with disabilities with professionally and ethically sound services, including provision of assessments and interventions.

The goal of these *Guidelines for Assessment of and Intervention with Persons with Disabilities* is to help psychologists conceptualize and implement more effective, fair and ethical psychological assessments and interventions with persons with disabilities. The *Guidelines* provide suggestions on ways psychologists can make their practices more accessible and disability-sensitive, and how they might enhance their working relationships with clients with disabilities. Additionally, the *Guidelines* provide information on how psychologists can obtain more education, training and experience with disability-related matters.

The Task Force hopes that the *Guidelines* will increase discussion, training and awareness about disability across the profession. Such interest might contribute to needed research on disability-related issues in assessments and interventions. In particular, we encourage the development and use of empirically informed treatments and assessments for clients with disabilities (Olkin & Taliaferro, 2005).

The Task Force based the Guidelines on core values in the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002; Smart, 2001; Szymanski & Trueba, 1994) with specific reference to Principle D: Justice and Principle E (Respect for People's Rights and Dignity). The core values include respect for human dignity, recognition that individuals with disabilities have the right to self determination, participation in society, equitable access to the benefits of psychological services, recognition that people with disabilities are diverse and have unique individual characteristics, and recognition that disability is not solely a biological characteristic, but is also a result of the individual's interaction with the environment.

Disability is a broad concept that encompasses a wide range of impairments, functional limitations, and barriers to participation in community life (World Health Organization, 2001). The Task Force recognizes that psychologists have a firm grasp on treating impairments that arise from issues of emotional disturbance and mental health disability. Accordingly, although our Guidelines apply to persons with all types of disabilities, including mental health, we emphasize issues of disability arising from the impairments which are less known to psychologists, such as mobility, sensory, communication, and neurological impairments. We also focus on environmental factors that influence all disabilities and accommodations that mitigate them.

The Task Force conducted an extensive literature search of psychological, medical, rehabilitation, vocational and educational databases, searching in the areas of professional relationship and communication issues, attitudes, biases and assessment and treatment of persons with disabilities across the developmental trajectory. The literature reviews were broad in scope, covering quantitative and qualitative traditions tied to various specialty areas in disability research (e.g., clinical rehabilitation, neuropsychology, education, psychometrics, counseling and vocational rehabilitation). Much of the identified literature was theoretical and professional, focusing on specific disabling conditions rather than generic disability. The Task Force used the results of those reviews in developing these guidelines.

This document offers guidance on how psychologists assess and treat people with disabilities in their professional capacity. Guidelines are not standards. Standards are generally mandatory and may have an enforcement mechanism. Guidelines are intended to facilitate the profession's continued systematic development and to ensure that psychologists maintain a high level of professional practice. Guidelines are not exhaustive and may not apply to every professional and clinical situation. They are not definitive and do not take precedence over a psychologist's well-informed judgment. Applicable federal and state statutes also supersede these Guidelines.

These *Guidelines* are intended for psychologists who work in various settings with clients who have disabilities. Settings may include outpatient therapy; educational, religious, or correctional facilities; businesses and employment settings; insurance, compensation and legal contexts, and hospital, rehabilitation and community service settings. They are meant to facilitate a psychologist's work with clients who have disabilities, not to restrict or exclude any psychologist from serving clients with disabilities or to require specialized certification for this work. The *Guidelines*

also recognize that psychologists who specialize in working with clients who have disabilities may seek more extensive disability training consistent with specialized practice.

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

Disability Awareness, Training, Accessibility, and Diversity

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

The term disability is not easily defined, yet the effects of its definition are far reaching. For example, different legal definitions have implications for obtaining services and benefits. Generally, disabilities are physical, mental and/or sensory characteristics that affect a person's ability to engage in activities of daily life (U.S. Department of Health and Human Services, 2005). The Americans with Disabilities Act (ADA) Amendments Act of 2008 defines disability as a physical or mental impairment that substantially limits a major life activity, or having a record of such impairment, or being regarded as having such impairment because of an actual or perceived physical or mental impairment. This holds even with the use of equipment designed to mitigate the disability. So, for example, a person with a hearing impairment that interferes with most social interactions would be considered as having a disability even if the use of an augmentative communication device significantly improves his or her ability to engage in conversations.

Views on the nature of disability have evolved over time. Although current models emphasize an ecological perspective, clients and therapists may hold beliefs about disability that are influenced by religious, cultural and medical beliefs. Awareness of these beliefs and how they may affect their clients with disabilities will facilitate clinical process and outcomes (Altman, 2001; Olkin & Pledger, 2003; Schultz et al., 2007; Smart & Smart, 2007).

The pre-scientific, *moral model* views disability as an embodiment of evil, a punishment for a family member's or ancestor's transgression, a divine gift, fate or a test of faith and opportunity to overcome a challenge (Groce, 2005; Mackelprang & Salsgiver, 1999; Olkin, 1999b). Without realizing it, psychologists or their clients may be affected by these deep-seated historical constructs in a way that influences their relationship. For example, a therapist may not understand a client who, based on the moral model, feels challenged by fate and a client, in turn, may feel pressured by a therapist to change circumstances seen as dictated by fate.

The scientific models of disability reflect medical, social construction and functional traditions of conceptualizing disability (Altman, 2001; Smart & Smart, 2007; Chan, Gelman, Ditchman, Kim & Chiu, 2009). The *biomedical model* views an individual's pathological condition or impairment as a medical problem that deviates from the norm (Gill, Kewman, & Brannon, 2003). The focus is on the person's deficits and elimination of the pathology or restoration of functional capacity. Most traditional psychological therapies (e.g. behavioral, cognitive-behavioral or psychodynamic) rely on this model to target symptom removal or adjustment to disability. Holding this view may lead a client to solely focus on the hope for a cure and to ignore how to move on with the tasks of life and adapt.

The *social model* holds that disability is a product of the ongoing interaction between individuals and their environments (DePoy & Gilson, 2004; Gill et al., 2003; Hahn, 1999; LoBianco & Sheppard-Jones, 2007; Longmore, 1995; NIDRR, 1999; Smart, 2001; Smart & Smart, 2007). This model focuses on the dynamic interactions of their individual characteristics (e.g., conditions, functional status, personal and social qualities) with the natural, built, cultural, and social environments (NIDRR, 1999). For example, a newly hired individual with a disability who uses a walker to aid mobility may face physical and attitudinal barriers to work and negotiate appropriate accommodations with the employer.

The *social model* illuminates how environments may impede or facilitate individual functioning by erecting or removing barriers to full participation (Linton, 1998) while emphasizing social and functional accommodations. Solutions include using universal design to create accessibility for everyone, allowing individuals with disabilities to make their own decisions, educating the public about disability issues and attitudes, and enforcing laws to ensure equal access and protection (Olkin, 1999b; Smart, 2001). In this model, a psychologist can facilitate a client's positive disability identity and self-advocacy skills, or consult with others to ensure that the client has adequate accommodations, opportunities for participation, and a voice in decision making.

The *functional model* is pragmatic and cross-diagnostic. It conceptualizes disability as a social consequence of functional capacities and limitations (Nagi, 1965; Smart, 2001; Chan et al, 2009). It assumes that the relationship between functioning and disability is best understood in the context of social and occupational demands. For example, a finger amputation may lead to a disability in a violinist but not in a business executive. In this model, psychologists can facilitate a client's functional improvement and the development of strategies that compensate for limitations, given life demands and supports.

As practiced in forensic psychology and neuropsychology, the *forensic model* of disability is neither social nor purely medical. It centers on legal concepts rather than individual experiences of disability. This model requires objective proof of impairment and disability and determination of the honesty and motivation of individuals seeking recognition, benefits or compensation for disability. For psychologists, this model has fostered a proliferation of psychological approaches to detect secondary gain, malingering, feigning, symptom exaggeration, and invalid or poor effort (Dersch, Polatin, Leeman, & Gatchel, 2005; Schultz, Crook, Fraser, & Joy, 2000; Schultz et al., 2007; Stowell, 2005). From a client's perspective, the emphasis on proof may undermine the development of trust that is central to building a clinical relationship, or alternately, validate their experience.

The World Health Organization's *International Classification of Functioning, Disability, and Health* (ICF) model of disability integrates the medical, social and functional dimensions and provides a positive, enablement-focused rather than disability-oriented framework. It views disability as restriction in participation in life activities and as an interactive construct (WHO, 2001, Peterson, 2005; 2001). The ICF assesses domains such as body function and structure, activity and participation, and personal and environmental factors such as access to transportation. In the ICF, functional limitations of impairment become disabling in the context of broader physical, social and attitudinal factors (Chan et al, 2009; Peterson, 2005; Schultz et al., 2007). Psychologists in various specialty areas are translating this model for psychological research and practice (Bruyère & Peterson, 2005; Bruyère, Van Looy & Peterson, 2005;

Reed et al., 2005). They emphasize the importance of using measures of constructs mapped by the ICF and recommend linking the ICF-postulated assessment model to individual and social interventions (Chan et al, 2009).

Guideline 2: Psychologists strive to examine their beliefs and emotional reactions toward various disabilities and determine how these might influence their work.

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

One such assumption is the “spread” effect in which a psychologist might assume that any client with a disability must have certain related characteristics (Livneh, 1982; Olkin, 1999b; Wright, 1983). For example, a psychologist might believe that a person with a spinal cord injury has no interest in sex. A psychologist may also misattribute a psychological characteristic to having a disability, such as assuming that a person’s shyness is attributable to having a limb loss without considering other explanations.

Research suggests psychologists tend to believe problems experienced by clients with intellectual disabilities are attributable to their disability as opposed to psychological conditions, such as depression (Mason & Scior, 2004; Nezu & Nezu, 1994; Reiss, Levitan, & Szyszko, 1982). This misperception is an example of diagnostic overshadowing, i.e. over-emphasizing or mistakenly focusing on a client’s disability while ignoring important aspects of one’s life, such as life events, capabilities and strengths, and other issues related to the client’s presenting problems (Jopp & Keys, 2001; Kemp & Mallinckrodt, 1996; Mason, 2007; Reiss et al., 1982; White, Nichols, Cook, & Spengler, 1995). Conversely, psychologists may under-emphasize disability-related concerns, or even assume clients use their disabilities as an excuse. For example, a couples’ therapist might fail to ask about a client’s physical needs before suggesting that one is using disability-related concerns as an excuse to not move into the significant other’s home.

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

Self examination and familiarity with disability-related issues are two ways to minimize biases, faulty assumptions and negative emotional reactions (Blotzer & Ruth, 1995; Olkin, 1999b; Vash & Crewe, 2004; Wilson, 2003). The following are practical suggestions for psychologists to accomplish these two tasks:

- a. Examine preconceptions, beliefs and emotional reactions towards persons with disabilities.
- b. Consider how disability-related and other life experiences, separately or together, might be related to the client’s current problems.
- c. Assess the client’s strengths and weaknesses and incorporate them into interventions.

- d. Emphasize the client's possibilities rather than limitations in social, vocational, and educational endeavors.
- e. Integrate disability-related case material and topics into professional discussions, study groups and seminars.
- f. Identify and contact professionals in the community who can provide consultation and/or supervision when needed.
- g. Become familiar with disability resources in one's communities. Examples of resources might include local Centers for Independent Living, state assistive technology projects and advocacy groups.

The current APA Ethics Code (APA, 2002) addresses unfair discrimination, competence, and bases for judgment in Standards 3.01, 2.01, and 2.04 respectively.

Guideline 3: Psychologists strive to increase their knowledge and skills about working with individuals with disabilities through training, supervision, education, and expert consultation.

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

Professional journals and various professional organizations publish a wide range of research and practice literature relevant to working with people with disabilities. For example, disability-related articles appear in several APA journals. The following APA divisions among others offer disability-relevant information and research: Division 22 (Rehabilitation Psychology); Division 27 (Society for Community Research and Action); Division 33 (Intellectual and Developmental Disabilities); Division 40 (Clinical Neuropsychology), and Division 43 (Family Psychology).

Developing and regularly consulting with a network of colleagues may facilitate ethical decision making. The APA Committee on Disability Issues in Psychology, the APA Ethics Committee, the ethics committees of state psychological associations, and state and national boards of psychology are also good resources for ethical decision-making (Rae et al., 2001).

Guideline 4: Psychologists strive to learn about federal and state laws that support and protect people with disabilities.

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

Sections 503 and 504 of the Rehabilitation Act of 1973 (Public Law 93-122) prohibit disability-based discrimination by federally funded institutions. This law has increasingly been used in schools to provide services for children who do

not qualify under IDEA. Sections 503 and 504 do not apply to non-federally funded institutions and do not provide administrative procedures for getting accommodations or the due process available under IDEA (Rae, Fournier, & Roberts, 2001).

The ADA and the ADA Amendments Act of 2008 provide comprehensive civil rights protection to individuals with disabilities. Title I prohibits discrimination in employment on the basis of a disability for qualified individuals who, with or without a reasonable accommodation, are able to perform the essential functions of a job. Employers are expected to provide reasonable accommodations for people with disabilities (ADA, 1993; Bruyère & O’Keeffe, 1994). ADA’s Title II prohibits excluding a qualified individual with a disability, by reason of such disability, from participating in or securing the benefits of services, programs, or activities of a public entity (42 U.S.C § 12131 et seq.). This title includes all aspects of school programs, facilities, and services. Title III promotes accessibility for “places of public accommodations (42 U.S.C § 12181-12189 et seq.) and the Americans with Disabilities Act Accessibility Guidelines (United States Access Board, 2004) specify the standards such entities must meet. Title IV covers telephone and television access for people with hearing and speech disabilities. It requires telecommunication companies to provide interstate and intrastate relay service 24 hours a day, 7 days a week to individuals who use telecommunication devices for the deaf (47 U.S.C. § 201 et seq.). Title V includes miscellaneous provisions, such as the recovery of legal fees for successful proceedings pursuant to the Act. It also prohibits coercing, threatening, or retaliating against people with disabilities or those attempting to aid people with disabilities in asserting their rights under the ADA (42 U.S.C 12201 et seq.).

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

The federal laws are enforced by the Department of Justice, which relies on the reports and complaints of individuals with disabilities in order to take action. The intersection of laws and policies needs to be considered, as well as the fact that at times policies regarding service access (e.g. disability) may be incompatible with other service access policies (e.g., aging). State laws may provide more protection than federal laws for citizens with disabilities, but never less protection.

Guideline 5: Psychologists strive to provide a barrier-free physical and communication environment in which clients with disabilities may access psychological services.

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

Clients with disabilities need accessible transportation services in order to get to a psychologist's office. An office location with nearby accessible public transportation enhances access to services for clients with disabilities. However, at times, public transportation may entail effort, time and cost. It is also helpful to be aware of other accessible transportation options, such as wheelchair-accessible van services.

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

Communication access also accommodates various disabilities. Clients with communication disabilities may require quiet environments and appropriate use of specific methods or technology to facilitate psychological service delivery. Privacy concerns must be addressed and communication choice respected. Clients with speech disabilities may communicate with alternative or augmentative communication such as speech boards, speech synthesizers or computers. Clients with hearing loss and/or speech disabilities may call or be called via telephone relay services, internet relay services, and video relay services. Each service uses operators sworn to confidentiality to facilitate communication (Federal Communications Commission, 2006). Other clients may prefer to use cell phone text messaging and secure electronic mail, or secure videophone or teletype equipment. Sign language interpreters or computers may be used for interpersonal communication during sessions. Clients with cognitive disabilities or various linguistic needs may require simplified, easy-to-understand documents, such as office paperwork (Wehmeyer, Smith, & Palmer, 2004). Clients with visual disabilities may need documents in large print, as text files on disk, or in Braille (Lighthouse International, 2006; Olkin, 1999b).

Clients with disabilities need access to informed consent. The client with a disability must provide consent in the manner prescribed for all clients by Standards 3.10, 9.03, and 10.01 of the APA Ethics Code (2002) with the exception of specified activities such as routine educational testing or the evaluation of decisional capacity (e.g. severe dementia). Special considerations include communication barriers and the use of interpreters discussed earlier, using consent language that the client can reasonably understand, and respectfully evaluating the need for consent by legal guardians (Fisher, 2003).

Guideline 6: Psychologists strive to use appropriate language and respectful behavior toward individuals with disabilities.

One way to respect the dignity and worth of all people (Principle E of the APA's Ethical Principles, 2002) is to support the use of disability-sensitive language. APA's Publication Manual (2010) cautions against using language which equates individuals with their conditions (e.g. the disabled or the psychotic), or demeans such individuals. Such language may bias diagnostic and intervention processes (Simeonsson & Scarborough, 2001).

Language may reveal our attitudes toward people with disabilities (Hauser, Maxwell-McCaw, Leigh, & Gutman, 2000). Excessively positive language (e.g., "heroic", "despite his disability" or references to "overcoming disability") or

excessively negative language (e.g., “afflicted with”; “suffering from” or “confined to wheelchair”) regarding people with disabilities focuses on stereotypes, rather than individuals (Katz, Hass, & Bailey, 1988). People-first language (e.g., a woman with multiple sclerosis; a student who is depressed) is typically used to maximize focus on the person (APA, 2010). However, other individuals prefer disability-first language (National Federation of the Blind, 1993; Sinclair, 2007). It is important to avoid stereotypical or derogatory phrases that imply deficiency or inadequacy such as “deaf mute” since a deaf person is perfectly capable of intelligent communication (Gill et al., 2003; Khubchandani, 2001; Olkin, 2002).

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

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

With patience, psychologists can enhance and accommodate their clients’ communication by acknowledging that it may take extra time to communicate effectively with a client who has a disability (Leigh & Brice, 2003). Sensitive psychologists will adjust their listening to the client’s rate of speech. A client with a visual disability may need specific descriptions to enhance awareness of the immediate environment. It helps to articulate words clearly and pause between statements for clients who have language processing disabilities. A psychologist can first say the name of a client with an attention disorder, make eye contact with the client, and then proceed with verbal communication. Some clients may use visual communication systems, speech synthesizers, other specialized approaches, or sign language interpreters (Olkin, 1999b). The best way to facilitate clinical work is to ask the client about communication preferences and to consult experts for additional information, if needed. Such steps are critical to ensure accurate representation of the client in determining assessment outcomes and therapy procedures.

Guideline 7: Psychologists strive to understand both the common experiences shared by persons with disabilities, and the factors that influence an individual’s personal disability experience.

The presence of a disability reveals little about a person (Dunn & Dougherty, 2005; Olkin, 1999b). In addition to their own disability experiences, and those experiences which they share with other people who have disabilities, individuals with disabilities have unique life histories. Becoming acquainted with the experience of living with a disability increases empathy and understanding, and thus enhances assessments and interventions.

Daily hassles are a common disability experience. A person who uses a wheelchair may need a friend to verify that a restaurant has an accessible bathroom before deciding to eat there. A student with a visual impairment must make arrangements to obtain an alternative format (e.g., large print, electronic version) of a textbook or secure the services of a reader. A person with a brain injury may need to use special mnemonic devices or procedures to complete errands or juggle medical appointments. Such added challenges can be frustrating, exhausting and time-consuming.

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

The dimensions of an individual's disability may influence personal experiences. For example, individuals with visible disabilities may feel marginalized. The stares and questions of others often make them feel as if they are on display (Olkin, 1999b). Individuals with invisible disabilities (e.g. learning disabilities, mental health disabilities, chronic pain) **may** have difficulty convincing others that they have a disability (Smart, 2001; Taylor & Epstein, 1999). Other aspects of disability that may affect a person's disability experience include functional capacities, energy levels, pain, age of onset, manner of onset (e.g., military trauma), and whether the disability is static, episodic, progressive.

People with disabilities, like all people, have influences in their lives that contribute to their development, such as their culture, religion, family of origin, community, schooling, friends, significant others and co-workers. Such common influences may shape a person's individual disability experience. For instance, different parents of children with disabilities may impart very different messages about what it means to have a disability. One child may be protected from risk, while another is expected to tackle challenges. Similarly, a person with an intellectual disability who lives in a community that is inclusive of people with disabilities will likely have more positive self-image than a person without such opportunities.

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

Guideline 8: Psychologists strive to recognize social and cultural diversity in the lives of persons with disabilities.

The intersection between multiple identities impacts any person's experience and social opportunities. To work effectively with clients who have disabilities, it is important for psychologists to consider how a client's disability-related issues interact with his or her other cultural and social identities and experiences.

In the United States, African American, American Indian, and Latina/o adults are more likely to have a disability than their non-Latina/o White, and Asian/Pacific Islander counterparts (U.S. Census Bureau, 2000). Higher rates of disability in people of color are related to several factors, including disproportionately high levels of poverty and unemployment, and disproportionately low levels of formal education and access to health care (e.g., Flack et al., 1995).

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

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

Individuals with disabilities who are also lesbian, gay, bisexual, or transgender face unique challenges. The larger society, and possibly their own families, are more likely to ostracize them (Olkin, 1999b) and, like their heterosexual counterparts, they may have difficulty finding partners.

Children and adolescents with disabilities are another vulnerable group. When working with children and adolescents with disabilities, psychologists often take a systems approach including family members, peers, schools and others. Psychologists are encouraged to promote inclusion, full accessibility and emphasize possibilities and opportunities for academic and social development (Olkin, 1999). In their school, many students with disabilities have assessments to develop Individual Education Plans (IEP) and undergo psychological, behavioral and educational interventions. Consequently, it is important for psychologists to understand the developmental needs of children and adolescents with disabilities and combine this understanding with solid knowledge of how to conduct fair and valid assessments and interventions from developmental, systems and functional perspectives.

Older adults are more likely to experience disability, since the prevalence of disability increases with age (U.S. Census Bureau, 2000). Some older adults come to old age with disabilities; others sustain a disability in old age; still others come to old age with disabilities and sustain further disabilities as they grow older. When working with older adults with disabilities, psychologists may also work with the family members and service providers. Older adults often lack qualified providers and adequate community services (Wacker & Roberts, 2008) partially because disability can be erroneously conceived as an inevitable aspect of aging and thus not requiring intervention.

Where one lives also affects the experience of disability. For example, rural Americans lack access to the wide range of services and supports available in urban areas (Seekins, 1995; Stamm et al., 2003). They must spend time and money traveling to access critical services. Psychologists working in rural areas may serve clients in a wide variety of geographical settings and can accommodate them by allowing for necessary travel.

Many people with disabilities also live in poverty (Lustig & Strauser, 2007). Disability and poverty are reciprocal — disability increases the risk of poverty; being poor with decreased access to health care, transportation, and assistive devices increases the risk of disability.

Other APA Guidelines discuss working with clients from diverse cultural and social backgrounds. Psychologists are encouraged to read these in order to work more effectively with clients from diverse backgrounds who also have disabilities.

Guideline 9: Psychologists strive to learn how attitudes and misconceptions, the social environment, and the nature of a person's disability influence development across the lifespan.

Individuals with disabilities face the same developmental tasks and milestones as anyone, such as forming friendships with peers, pursuing an education, developing a cohesive identity, becoming sexual and establishing intimate relationships, getting a job, conceiving and raising children, and dealing with advancing age. For individuals with disabilities, the ability to achieve developmental goals often depends less on the nature of their disabilities than on their personal relationships with family, significant others and friends, and systemic interactions with their schools, employers, healthcare providers and communities (Goodley & Lawthom, 2006; Olkin, 1999b; Reeve, 2000; Woolfson, 2004). For example, to transition successfully into adulthood, a high school student with a learning disability needs an encouraging and supportive family and a school that provides appropriate academic and vocational preparation. To negotiate aging successfully, a person with a spinal cord injury may need accessible community supports, personal assistance services, and assistive technology.

Societal attitudes and biases may also restrict an individual's opportunities for typical development (Murray, 2006; Woolfson, 2004). For example, a professional who predicts that a teenager with a mild intellectual disability cannot work and will need constant supervision may convince the parents to treat their child in ways that restrict opportunities for successful adult development.

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

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

Guideline 10: Psychologists strive to recognize that families of individuals with disabilities have strengths and challenges.

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

Despite these issues most families of people with disabilities are resilient. They meet these challenges and enjoy a quality family life by realigning their priorities, balancing the needs of all family members, and by deciding what is important in life (Goodley & Tregaskis, 2006; Rosenthal, Kosciulek, Lee, Frain & Ditchman, 2009; Wilgosh, Nota, Scorgie, & Soresi, 2004; Wilgosh & Scorgie, 2006). For many families, disability can be a meaningful growth experience. Family members recognize their own personal strengths, such as patience, humor, and problem solving skills, while experiencing greater empathy for and understanding of others (Goodley & Tregaskis, 2006; Scorgie, Wilgosh, & McDonald, 1996; Scorgie, Wilgosh, & Sobsey, 2004).

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

Disability may not be a salient factor when the family of a person with a disability seeks psychological services. However, psychologists are encouraged, when appropriate, to include families in assessments and interventions to help manage stress, develop resiliency, enhance quality of family life, and resolve feelings about disability (Bailey Jr. et al., 2006; Ehrmann & Herbert, 2005; Power & Dell Orto, 2004; Rosenthal et al, 2009; Scorgie et al., 2004; Turnbull & Turnbull, 2001; Wilgosh et al., 2004). The resiliency model of family stress, adjustment and adaptation (Kosciulek, McCubbin & McCubbin, 1993; Rosenthal et al, 2009) utilizes a systems approach and is particularly useful in describing and conceptualizing family interventions. Family reactions to disability may not necessarily reflect mourning and loss, but instead may be related to uncertainty about the present and future. For example, parents of an infant with a disability may not be mourning the loss of an idealized child. Their anger, fear and confusion may stem from their concern about their child's future and how to afford expensive medical care.

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

Guideline 11: Psychologists strive to recognize that people with disabilities are at increased risk for abuse and address abuse-related situations appropriately.

People with disabilities are often vulnerable to violence and abuse (Hassouneh-Phillips & Curry, 2002; Horner-Johnson & Drum, 2006; Hughes, 2005; Sullivan & Knutson, 1998). Compared to youth without disabilities, children and adolescents with disabilities may be three to ten times more likely to be abused or neglected (Sullivan & Knutson, 2000), particularly those with behavior disorders, intellectual disabilities, communication disorders, or multiple disabilities (Sullivan & Knutson, 1998). Women with disabilities, especially older woman, are at elevated risk of abuse (Brownridge, 2006; Martin, Serte-Alvarez, Kepper, Meracco, & Prickers, 2006; Smith, 2008), and they experience abuse for longer durations than women without disabilities (Nosek, Foley, Hughes, & Howland, 2001). Although men with disabilities experience similar types of abuse, society often fails to recognize this (Saxton, McNeff, Powers, Curry, & Limont, 2006). People with disabilities are at risk for abuse because they are perceived to be powerless, easily exploited, and may be physically helpless, socially isolated, emotionally deprived, and/or sexually naïve. Perpetrators have less risk of being discovered, and people with disabilities are less likely to be believed if they do report abuse or neglect (Andrews & Veronen, 1993; Nosek, Foley et al., 2001; Sobsey, 1994).

In addition to emotional, physical and sexual abuse, people with disabilities are vulnerable to disability-specific abuse. Violence against individuals with disabilities can include the withholding or excessive administration of medications, involuntary confinement, withholding or dismantling assistive equipment (e.g. wheelchairs), and withholding personal assistance for essential daily living activities such as eating and personal hygiene (Hughes, 2005; Nosek et al, 2001; Saxton et al., 2001). In institutional or community settings, individuals with disabilities who use personal assistance services experience a high incidence of neglect, verbal and/or physical abuse, and financial exploitation at the hands of their assistants (Oktay & Tompkins, 2004; Powers, Curry, & Oschwald, 2002).

Abuse and neglect may be the initial cause of a disability, may exacerbate an existing disability, and may contribute to depression and other emotional difficulties (Kendall-Tackett, Lyon, Taliaferro, & Little, 2005; Mitchell & Buchele-Ash, 2000; Olkin et al., 2006).

Nosek, Hughes, and Taylor (2004) suggest that psychologists:

- a. know the signs, symptoms, and dynamics of disability-related violence, including the unique areas of vulnerability noted above;
- b. screen for abuse and neglect, and intervene appropriately;
- c. document the history of abuse and neglect;
- d. discuss safety planning with clients, such as having a safe retreat, back-up personal care assistance, and social supports;
- e. maintain current contact information for accessible local domestic violence/sexual assault programs and disability service providers (e.g., Centers for independent Living);
- f. learn state mandatory reporting requirements for violence against people with disabilities including children, older adults, and dependent adults, and when appropriate involve the survivor throughout the reporting process; and
- g. be aware of potential long-term consequences of reporting, including possible deterioration in quality of care and the need for accessible domestic violence shelters.

Guideline 12: Psychologists strive to learn about the opportunities and challenges presented by assistive technology.

Assistive technology is defined as equipment, products, or systems that improve the functional capabilities of people with disabilities. Assistive technology includes ventilators that help people breathe; robotics to facilitate limb movement; vans with ramps or lifts for transporting people who use manual and power wheelchairs and scooters; baby-care equipment, adaptive eating utensils; hearing devices and text pagers; reading technology (e.g. JAWS computer screen-reading software; the Kurzweil Reader which converts text to speech) for people with visual or learning disabilities; and programs to simplify written language for individuals with neurodevelopmental disabilities (Vensand et al., 2000; Wehmeyer, 2006; Wehmeyer, Smith, & Davies, 2005). Computers with touch and/or voice activated programs and assistive devices allow users with communication disabilities to use a laser wand (usually attached to the person's head) to choose symbols or spell words, construct sentences, and "speak" with a synthesized voice (Beukelman & Mirenda, 2005; Wehmeyer et al., 2005).

A psychologist needs to understand that this technology may have advantages and disadvantages. In addition to the opportunities it offers people with disabilities, it imposes the responsibilities of researching new technologies and assistive devices; learning to use new technology (Pell, Gillies, & Carss, 1999); and funding and maintaining equipment (NTFTD Report, 2004). Matching person with technology is best done by assessing milieu, personality, and technology (e.g., Scherer, 2002, 2004). People may be frustrated when unavailable, unaffordable, or inaccessible technology (e.g. some web sites) limits their opportunities (Flowers, Bray, & Algozzine, 1999). While assistive technology may increase a person's independence, it may also pose a social barrier that makes the user seem too different or somehow deficient (Lupton & Seymour, 2000). Even when one person eagerly uses technology to attain objectives or enhance his life, another may find it overwhelming. Although not all people with disabilities and their families value are interested in or are enthusiastic about assistive technology, understanding how it can affect a user's self-image, self-efficacy, and coping and adaptation skills is important.

Finally, keeping up with the rapid advances in technology is difficult. Psychologists can check their state assistive technology center or refer their clients to appropriate local assistive technology service providers.

Testing and Assessment

Guideline 13: In assessing persons with disabilities, psychologists strive to consider disability as a dimension of diversity together with other individual and contextual dimensions.

When conducting psychological assessments in clinical settings, it is essential to consider the interaction between the individual with a disability and his or her environment. The dimensions of this interaction include how the individual functions over time, in varied situations, and in response to changing environmental demands (Bruyère & Peterson, 2005; Bruyère et al., 2005; Peterson, 2005; Radnitz, Bockian, & Moran, 2000; Reed et al., 2005; Scherer, 1998; Simeonsson & Rosenthal, 2001). Considering the central role of contexts in assessing a person's psychological functioning is consistent with the International Classification of Functioning, Disability and Health (ICF) integrative model of disability (WHO, 2001). For example, understanding co-workers' attitudes, family members' responses,

classroom design elements, or the effect of school or work accommodations is important in assessing individuals with disabilities (Bruyère & Peterson, 2005; Bruyère et al., 2005; Chan et al, 2009; Hurst, 2003 & Szymanski, 2000 (both as cited in Reed et al 2005); Peterson, 2005; Reed et al., 2005).

As a complement to the contextual approach in clinical settings, a psychologist may also assess the relationship between an individual's capacities and limitations. Some psychologists view cognition, functional status and life history as "core capacities" (Scherer, 1998). Coping and adaptation are additional capacities (Chronister, Johnson & Lin, 2009; Heinemann, 1995 as cited in Cushman & Scherer, 1995). Other factors that might be assessed include positive psychology concepts such as seeking meaning and positive growth (Dunn, 1996; Elliott, Kurylo, & Rivera, 2002; Heckhausen & Schulz, 1995; Kennedy et al., 2000; Tennen & Affleck, 2002) and optimism and self-determination (Marini & Chacon, 2007). Conducting a personality assessment can help a psychologist understand the meaning of disability in a client's life and the way in which the client is likely to experience intervention.

Results of established methods and instruments used in neuropsychology and rehabilitation, clinical, counseling, forensic, and educational psychologies should be interpreted with reference to the strengths as well as the limitations of individuals with disabilities. In all specialty areas, it is important for psychologists to assess various qualities in a person with a disability in context, rather than the disability alone.

Guideline 14: Depending on the context and goals of assessment and testing, psychologists strive to apply the assessment approach that is most psychometrically sound, fair, comprehensive, and appropriate for clients with disabilities.

Professional associations have developed many documents to govern testing practices: the *Code of Fair Testing Practices in Education*, *APA Test User Qualifications* (2000), *Ethical Principles of Psychologists and Code of Conduct* (2002), *NASP Professional Conduct Manual* (2000), and *Rights and Responsibilities of Test Takers: Guidelines and Expectations* (Joint Committee on Testing and Practices, 1998). However, the *Standards for Educational and Psychological Testing* (1999, hereafter referred to as the Standards) is the document that is most specific in describing the appropriate uses of testing. The Standards make the distinction that, in applied settings, psychologists strive not just to test individuals, but to assess individuals: "The label test is ordinarily reserved for instruments on which responses are evaluated for their correctness or quality. Assessment is a broader term, commonly referring to a process that integrates test information with information from other sources. Psychological assessment involves solving problems or answering questions (Vanderploeg, 2000) and, in addition to reviewing test results, may incorporate multiple data collection methods: behavioral observation, an interview with client(s), collateral interviews, and reviews of case records (Vanderploeg, 2000).

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

Disability status may significantly alter the meaning of test scores. Measures should strive to either include individuals with relevant disabilities in their norm groups or have separate norms. For example, some depression scales have been developed, normed, and validated on populations that do not include individuals with specific disabilities. These scales measure perceived health, pain and fatigue. When applied to an individual with a disability, the results may indicate depression, which may be an inaccurate interpretation.

Standardized assessment instruments may lack appropriate norms and/or may not accommodate clients with specific disabilities. In that case, the psychologist attempts to find instruments that maximize the collection of valid information. To judge whether it is appropriate to employ a measure used with the general population for clients with specific disabilities, it is important to read the manual or contact the test's publisher for more information (Geisinger, 1998).

Guideline 15: Psychologists strive to determine whether accommodations are appropriate for clients to yield a valid test score.

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

The 1999 *Standards* identified a variety of ways in which tests might be modified for administration to individuals with disabilities. These accommodations (or modifications) include (1) altering presentation format, (2) altering response format, (3) altering timing, (4) altering the test setting, (5) using only portions of the test, and (6) using substitute tests or alternative assessments. Changing the presentation format is a common accommodation for many individuals with disabilities. A paper-and-pencil test may be administered in Braille or audiotape formats, or computerized for use with a screen reader. Permitting test takers with disabilities to use alternative response formats allows them to record their answers in the most accurate way. Some test takers may also require assistance from an aide. To assure their

continued validity, tests justified with the general population on the basis of criterion-related validity may require separate validity studies of test takers with comparable disabilities.

Although altering the time allowed to complete a test is a controversial procedural change, especially for intellectual ability or academic achievement tests, researchers have found it is often a valid accommodation, especially for academic achievement tests. Allowing additional time is a primary accommodation (e.g., for individuals with learning disabilities), but sometimes it relates to another accommodation. For example, it takes more time to read Braille or large-print format tests than standard text tests because both Braille and large-print documents have many more pages to turn. An individual with an extreme movement disorder may have great difficulty filling in bubbles on an answer sheet; an alternative assessment tool may be appropriate. It is critical to continue to identify ways in which individuals with disabilities can be tested appropriately, either by using accommodations or employing different but similarly valid measures. It is possible to use a replacement or alternative measure, if it has comparable validity and is less influenced by the individual's disability.

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

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

Guideline 16: Consistent with the goals of the assessment and disability-related barriers to assessment, psychologists in clinical settings strive to appropriately balance quantitative, qualitative and ecological perspectives, and articulate both the strengths and limitations of assessment.

To maximize the validity of the assessment, psychologists are encouraged to apply integrative multi-method assessments rather than rely solely on any one type of data. The literature identifies three approaches to the psychological assessment of individuals with disabilities: quantitative, qualitative, and ecological (Simeonsson & Rosenthal, 2001; Parker & Schaller, as cited in Szymanski & Parker, 2003). Guidelines 13 and 14 discuss

quantitative assessment. Qualitative assessment focuses on observation and interview, and is idiographic and holistic. While few qualitative measures have been properly validated, some psychologists believe that qualitative measures may be especially useful in specific applications such as vocational assessment or when no psychometrically appropriate measures are available for a client whose severe or complex disabilities are a barrier to standardized assessment. Clients actively collaborate with the psychologist in this approach (Healy, 1990 as cited in Parker & Schaller, in Szymanski & Parker, 2003).

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

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

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

Functional assessment measures how a person interacts with the environment and focuses on various domains of real-life skills that enable the person to independently engage in his/her environment (Halpern & Fuhrer, 1984 as cited in Crewe & Dijkers Chapter, in Bedell, 1994; NASP, 2000; Shriver, Anderson, & Proctor, 2001). It is particularly useful for clients who have disabilities, including those with multiple barriers to assessment. Functional assessment observes the client's living, working, social, and/or learning environments and portrays the extent of the client's adaptive behavior (Yoman & Edelstein, 1994). This assessment focuses on social behavior, activities of daily living, family, school or work behavior, communication, motor skills and functional academic skills and ensures disability accommodations in an assessment setting. For example, for the parenting capacity of an individual with mobility restrictions to be functionally assessed, the home environment needs to be appropriately adapted. Subsequently, both behavior and environment may become targets for intervention (Bruyère & Peterson, 2005; Bruyère et al., 2005;

Gaylord-Ross & Browder, 1991; McComas, Hoch, & Mace, 2000 as cited in Shapiro & Kratochwill, 2000; Peterson, 2005; Reed et al., 2005; Yoman & Edelstein, 1994).

Psychologists are encouraged to consider a multidisciplinary perspective in assessing clients with disabilities. Sometimes they can learn from their peers in other professional domains, including special education and clinical, occupational and community rehabilitation. For example, functional assessment of work-related communication and social skills of a person with severe brain injury may require a team comprising a psychologist or a neuropsychologist, a speech and language therapist, an occupational therapist, a vocational rehabilitation counselor and others. Importantly, psychologists performing assessments of persons with disabilities are encouraged to become familiar with key knowledge of disabilities to facilitate appropriate instrument selection, administration and interpretation.

Guideline 17: Psychologists in clinical settings strive to maximize fairness and relevance in interpreting assessment data of clients who have disabilities by applying approaches which reduce potential bias and balance and integrate data from multiple sources.

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

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

- a. delaying professional judgment and decision until after rather than during an evaluation (Sandoval, Frisby, Geisinger, Scheuneman, & Grenier, 1998);
- b. identifying personal preconceptions about persons with disabilities (Sandoval et al., 1998);
- c. examining integrative primary and competing hypotheses regarding client issues and validating them using both confirmatory and nonconfirmatory assessment (Sandoval et al., 1998; Ziskin & Faust, 1988);
- d. developing complex schemas or conceptions of clients with disabilities based on the pertinent literature and individual experience (Elliott & Umlauf, 1995; Groth-Marnat, 2003; Sandoval et al., 1998); and
- e. specifically addressing both strengths and weaknesses in functioning and focusing on the referral question (Schultz & Stewart, 2008).

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

also encouraged to consult the *Specialty Guidelines for Forensic Psychologists* (APA, 1991) and stay abreast of the literature. Similar care needs to be exercised in parenting, vocational capacity and other evaluations for court purposes.

Interventions

Guideline 18: Psychologists strive to recognize that there is a wide range of individual response to disability, and collaborate with their clients who have disabilities, and when appropriate, with their clients' families to plan, develop, and implement psychological interventions.

Psychologists provide interventions with persons with disabilities in a variety of settings including outpatient and inpatient facilities, schools, work, social service agencies and disaster sites. In working with clients who have disabilities, a psychologist does not automatically assume that certain treatment modalities, interventions, and theoretical orientations are appropriate or inappropriate according to the individual's type of disability. For example, a psychologist would not assume that a client with an intellectual disability could not benefit from individual psychotherapy (Butz, Bowling, & Bliss, 2000; Mason, 2007; Nezu & Nezu, 1994). Critical aspects of psychological interventions include establishing a secure working relationship, understanding the client's unique life and disability-related experiences, determining the client's treatment needs and collaborating to develop an intervention plan and goals. A client's disability may make this process more complex.

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

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

Guideline 19: Psychologists strive to be aware of the therapeutic structure and environment's impact on their work with clients with disabilities.

Persons with disabilities are the ultimate authority on their own needs. To support individual freedom and choice, the psychologist should attempt to provide a hospitable environment for psychological intervention (Banks & Kaschak, 2003), to understand how the individual's environment affects the disability and work with their clients to ensure that the therapeutic environment accommodates a client's disability.

Accordingly, the psychologist working with a client who has a disability is encouraged to:

- a. maintain the length of sessions flexible to accommodate the client's physical and psychological tolerances. For instance, when a client experiences fatigue due to travel or poorly controlled pain, a full-length therapy session may be too exhausting;
- b. tailor the number, nature, and frequency of sessions to the client's stamina, attention span, ability to process content of sessions, and transportation resources;
- c. accommodate the communication needs of clients with language processing, attention and memory problems by providing visual aids and written summaries, or audio-taping sessions; and
- d. at the beginning of therapy, as based on Standard 4 of APA's (2002) Ethical Code, explain to the client and any others who may accompany the client (e.g. interpreter, personal attendant, family member(s), or significant other) that the client has a right to confidentiality.

Guideline 20: Psychologists strive to recognize that interventions with persons with disabilities may focus on enhancing well-being as well as reducing distress and ameliorating skill deficits.

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

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

The choice of intervention depends on the client's reasons for seeking psychological services. Interventions may focus on increasing self-determination, or being empowered to make one's own decisions and choices about life (Duvdevany, Ben-Zur & Ambar, 2002; Nota, Ferrari, Soresi, & Wehmeyer, 2007; Shogren, Wehmeyer, Reese & O'Hara, 2006). Working with a client to develop his or her self-advocacy skills promotes self-determination (Goodley

& Lawthom, 2006; Olkin, 1999b; Reeve, 2000). Individuals advocating for their own social, economic and political opportunities and personal relationship needs may have a greater sense of empowerment and well being.

Guideline 21: When working with systems that support, treat, or educate people with disabilities, psychologists strive to keep the clients' perspectives paramount and advocate for client self-determination, integration, choice, and least restrictive alternatives.

Many community agencies and systems influence the lives and psychological well being of individuals with disabilities and their families (DeJong, 1979; DeJong, 1983; Heinemann, 2005; Hernandez, Balcazar, Keys, Hidalgo, & Rosen, 2006). The psychologist who works with organizations that serve individuals with disabilities promotes inclusive environments and supports clients with disabilities by consulting with individuals and groups, working with collaborative teams, and creating beneficial adaptations, accommodations as well as enabling environments. A psychologist may advocate for persons with disabilities and family members to participate in agency leadership roles.

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

Guideline 22: Psychologists strive to recognize and address health promotion issues for individuals with disabilities.

Psychologists recognize that disability is not synonymous with disease or illness. In fact, individuals with disabilities often lead healthy and independent lives, but may have a smaller margin of health and be at increased risk for preventable and/or manageable secondary health conditions that may affect their well being and participation in community life (Kinne, Patrick, & Doyle, 2004; Pope & Tarlov, 1991; Ravesloot, Seekins, & White, 2005; WHO, 2001). Given that physical and mental health are intimately related, psychologists can help clients with disabilities understand how maintaining health and preventing secondary conditions can help them achieve life goals. For example, maintaining an exercise program and diet might prevent Type II diabetes and help clients to obtain their goals more easily. When appropriate, psychologists learn about their clients' health issues, help their clients understand the relationship between health and well being, and encourage clients to practice healthy lifestyles that prevent both primary and secondary health problems (Gill & Brown, 2002; Heller, Hsieh, & Rimmer, 2002; Heller & Marks, 2002).

Psychologists are encouraged to read the Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities (2005), which states that professionals have a role in advancing the good health of persons

with disabilities. The Call to Action discusses the challenges, strategies, and research priorities required to help individuals with disabilities lead healthy and productive lives.

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Concluding Statements

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

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