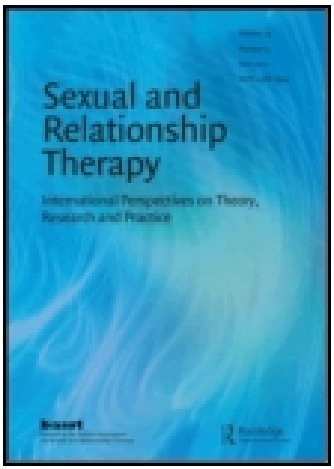

Sexual and Relationship Therapy

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/csmt20

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Published online: 25 Aug 2010.

To cite this article: Simon Parritt & Jean O'Callaghan (2000) Splitting the difference: An exploratory study of therapists' work with sexuality, relationships and disability, Sexual and Relationship Therapy, 15:2, 151-169, DOI: 10.1080/14681990050010745

To link to this article: http://dx.doi.org/10.1080/14681990050010745

Sexual and Relationship Therapy, Vol. 15, No. 2, 2000

Splitting the difference: an exploratory study of therapists' work with sexuality, relationships and disability

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ABSTRACT *This study explored sexual and marital therapists' experience of working with physically disabled clients. Data were collected using tape-recorded semi-structured interviews with six accredited female sexual and marital therapists and analysed using the Grounded Theory approach. A core dynamic emerged which suggested that there was a tension evoked by the perceived 'otherness' of the disabled client; this was managed by a splitting of the body/person and/or a distancing of themselves. This varied according to the therapist's previous experience of disability, either personal or professional. Participants reported little experience with disabled clients, although they employed an ill-defined and shifting definition of disability. Despite the extensive experience of participants they reported being anxious raising issues of disability and sexuality and found disabled clients evoked stronger emotional responses in them than other clients. Suggestions for further research are proposed, having in mind that increases in referrals and exposure to disabled clients may, on its own, be insufficient unless wider issues of access, training and supervision are addressed.*

Introduction

In recent years disabled people have increasingly challenged their role in society, supported by disabled researchers' published work elaborating The Social Model of Disability (Finklestein, 1981; Oliver, 1983; French, 1993). The emphasis upon independence and autonomy has led to pressure for more accessibility upon both the structural and socioeconomic environment. The passing of the Disability Discrimination Act (DDA) in 1996 has bolstered this, covering, among other things, the provision of services of which psychological services such as counselling and psychotherapy must be seen as part.

As more integrated members of society, physically disabled people like others will experience sexual and relationship difficulties, yet anecdotal evidence suggests that therapists and clinics see few physically disabled clients. Disabled people's uptake of any counselling is difficult to quantify, partly because of the lack of reports or studies which focus upon this client group and partly because classification itself

ISSN 1468-1994 print/ISSN 1468-1749 online/00/020151-19

is problematic when identifying physically disabled clients within the general client population. The World Health Organisation (WHO, 1980) defined disability as the resultant deficits of performance of activities as a result of physical impairment. Johnson (1996) builds on this, conceptualizing physical impairment as the deficits in structure or functioning of some part of the body, and social handicap as the deficits in social functioning. The model, however, lacks the broader perspective of the lived experience of disabled people themselves. This is reflected in a continuing debate concerning definitions which use a model based upon "able-bodied assumptions of disability" (Oliver, 1993: 61). Oliver sees this not just as a question of semantics but a challenge to researchers of find new ways of operationalizing "the concept of disability based upon the notion that disability is a social creation" (p. 66). There are likely to be many factors which contribute to understanding the uptake and availability of sexual and relationship therapy for physically disabled clients. Bearing in mind these issues, this research explores able-bodied therapists' own attitudes and internalized working models, allowing these to surface using only the term 'physical disability', thus attempting only to proscribe the inclusion of clients presenting with mental illness or learning disability.

There is considerable empirical evidence to suggest that people avoid social interaction with ill or disabled people because they find it difficult and distressing (Mills *et al.*, 1984; Dunkel-Schetter & Wortman, 1982; Goffman, 1963; Davies, 1961). Evidence also suggests that friends and family avoid those who become depressed because of their illness or disability and that health professionals' reactions are similar (Frank *et al.*, 1986). In the light of such evidence, do therapists react differently and how far do these processes impinge upon the therapeutic relationship and approach?

One widely quoted theory looking at social reactions to disability is Erving Goffman's (1963) social interactionist account of disablement in terms of 'stigma'. This approach takes as implicit the concept of 'fear of difference', which is seen as resulting from society's need to discriminate in order to protect itself in evolutionary terms. Finklestein (1981) challenges Goffman's use of 'stigma' as an interpretation in terms of 'blemish and ritual pollution' (Goffman, 1963) rather than power inequality; the implications of this for physically disabled clients presenting for sexual and relationship counselling could be profound.

The visual impact of difference can be immediate. A wheelchair user or amputee is immediately identifiable as 'different'. The sexual and relationship therapist's approach involves the body and mind as a source of pleasure and so there is no escape into a purely psychological and/or theoretical model. It is useful therefore to look at how people have reacted to visible impairments. The therapist 'sees' the person as physically different while discussing and questioning him or her about their sexual behaviour, thoughts and feelings. How do therapists 'see' and 'experience' disabled clients?

Research into disfigurement may offer some guide to the sort of issues this difference may bring up. Katz (1981) points towards the Old Testament, which lists several impairments that would disqualify a person from becoming a priest, largely as disability was seen as divine retribution, and these superstitions and myths still

run deep within society. Sickness and 'deformity' are seen as 'ills' and therefore can be causally linked to wrongdoing.

Bull & Rumsey (1988) in their summary of Livneh's (1982) work concerning attitudes towards disabled people refer to 'aesthetic aversion', which is a 'Repulsion and discomfort' (p. 220) around individuals with such impairments as amputations, skin disorders or body deformities. There was a belief that a person's own body may be affected by the presence of or contact with a disabled person. Anxiety about becoming disabled themselves may lead people to isolate and avoid disabled people (Dunn & Herman, 1982). One explanation, suggested by Siller (1976), is that anxiety is experienced when a person is confronted with something outside their construct system and that inadequacy and uneasiness when in the company of a 'disfigured person' may be the result of lack of experience. Therapists may be subject to this as they report seeing few physically disabled clients. Attitudes do not necessarily map directly to behaviour, but how far therapists are aware of these intervening processes, and their use of supervision, is of particular interest.

There is little research evidence of the impact of disability upon therapists. However, studies in the past have suggested that counsellors are influenced by client attractiveness (Bull & Rumsey, 1988: 249). Gething (1992) found that health professionals devalued wheelchair users applying for jobs both in respect of psychological adjustment and also general competence. However, most studies used student populations or trainees and employed video or photographs, and are therefore not necessarily useful when looking at the issue within a therapeutic relationship.

Not all reactions to physical disability are avoidant and there is some evidence to support the idea of a sympathy effect (Bailey, 1991). Therapists may be particularly prone to a 'sympathy' effect as a consequence of both their style of work and the intimate nature of the relationship. Do disabled clients who present in a particular way, perhaps social, intelligent and cooperative, put the therapist at risk of reacting primarily with sympathy?

Masters *et al*. suggest "It is impossible to understand human sexuality without recognising its multidimensional nature" (1982: 3). Sexual and relationship training can take a variety of forms but primarily it is by nature an integrative model. Besides being therapists, a considerable medical and biological knowledge of human sexuality is required in addition to a variety of behavioural 'tools' for the treatment of specific presenting conditions such a premature ejaculation or vaginismus. However, while therapists may use these behavioural techniques, they are also engaged in an holistic endeavour. With couples, they will be working with the dynamics of the relationship and with an individual they may be dealing with past life events or relationships. Asking specific questions about a client's sexuality will include intimate disclosures of fantasy, sexual activity, thoughts and feelings. This requires a level of confidence and trust in the relationship, as well as a clear and open approach by the therapist who models this behaviour for the client. Do therapists find physical disability interferes with this genuine and open approach?

Experienced therapists are likely to have seen a wide variety of clients in terms of age, socioeconomic group, culture and sexual orientation. They

will have been presented with a wide range of issues from organically based difficulties through to paraphillias and minority sexual preferences. How far does this experience alter therapists' reaction to the 'unusual' or 'different' and make them – unlike the general population – less likely to see disabled people's sexuality as at best a mystery, at worst deviant. In *The Sexual Politics of Disability* Shakespeare *et al.*(1996) point to the neglect of policy and provision around sexuality, which is a highly significant area for most adults. This is seen as reflecting "a failure to consider disabled people as fully human. Just like elderly people, disabled people are not seen as having sexual needs, and provision consequently neglects this" (p. 87). Recent writers (Kroll & Levy Klein, 1995; Williams, 1993) have written about disabled people being perceived as asexual, yet the disabled client confronts the therapist with the embodiment of the contradiction of that myth. Is the day-to-day experience of therapists in dealing with dispelling myths and misconceptions around sexuality, broad enough to encompass disability or is disability 'different' for them?

There is little published research which focuses on physical disability and therapy, and sexuality and disability has received even less attention. Controversy over definitions and the fact that, while The Social Model of Disability has been used widely in sociology, its theoretical application to counselling psychology and psychotherapy is uncertain, have further hindered research. This exploratory study offered an opportunity to examine one facet of this area, being the sexual and relationship therapist's experience of working with physically disabled clients.

Method

Design

Grounded theory as a qualitative approach offered the most appropriate method of enquiry, given the sensitive area under investigation and because the focus was upon the actual experience of therapists working with physically disabled clients. Our approach was designed in accordance with the inductive, interpretative and constructivist nature of the grounded theory approach (Strauss & Corbin, 1990; Henwood & Pigeon, 1995) which allowed the exploration of the 'lived experience' of therapists' experience with disabled clients where there is a dearth of existing models or theories.

The researcher focused on the following open questions in a semi-structured interview format:

- How did you come to be working with disabled clients?
- What do you consider is your 'working definition' of disability?
- What is your initial and ongoing reaction to a disabled client?
- How does your response vary between disabled and other clients?
- How was supervision or other professional support useful?

Towards the end of the interview participants were also asked about how they felt talking to a male disabled researcher about sexuality and disability.

Self-interview

Before carrying out interviews with participants, the researcher recorded his own responses to the research question. This was conducted as part of the process of 'taking care of' what O'Callaghan (1996) refers to as the possible "idiosyncratic biases" of the researcher. As this researcher is both a disabled person and a trained sexual and relationship therapist, it was of particular importance to 'bracket off' his own biases so as to avoid influencing the interview process. This enabled the researcher to be more aware of his own agenda and position in the research process.

Pilot study

Pilot interviews with male and female therapists were undertaken using an open-ended semi-structured interview. The resultant interviews were used to assist in assessing the impact upon interviewees of discussing sexuality and disability with a practitioner/researcher who was visibly physically disabled. As this could prove to be a powerful variable it was explored by drawing attention to it and then asking interviewees to reflect upon their experience of this at the end of the interview.

Based upon these pilot interviews, changes were made to the format and content of the interview. In addition to raising the issue of the researcher being disabled, other items added were the role of supervision and the therapists' experience at their initial meeting with a disabled client. There was some uncertainty among the therapists as to who might be classified as physically disabled, an issue that was noted for the main study.

Main study

Participants. Six female therapists were recruited following a leaflet requesting participants, which was sent to psychosexual training institutions and clinics, and an open letter to all accredited BASMT therapists who lived or worked within a large metropolitan area. Thirty-three questionnaires were returned and14 of those who had filled in a questionnaire were willing to be interviewed. Fifty two percent (17) respondents identified less than 10% of their case load as having been physically disabled in the past 12 months and 39% (13) had seen no disabled people. Female therapists were selected as there were insufficient male volunteers, perhaps reflecting the lower percentage of male therapists who responded (24%). All respondents had worked or trained at NHS clinics in major British cities, were over 40 years of age and had been working as sexual and relationship therapists for between eight and 23 years. Details of those who were interviewed in depth can be seen in Table I.

Procedure. Six semi-structured interviews were conducted. An attempt was made to allow the participants to talk freely while also ensuring the focus was maintained on the main area of the research question. The interviews were transcribed and analysed using the qualitative approach of grounded theory. In accordance with the concept of grounded theory, the literature search was deferred until after analysis in

TABLE I. Participants' age range and years of experience

	Sex	Age group	Years working	Current work settings	Disabled clients in last year	Percentage of client load	Accrediting Body
1	F	51–60	12	Private practice, NHS clinics	—	< 10%	BASMT UKCP
2	F	51–60	10	Private practice, Private hospital	one	< 10%	BASMT UKCP
3	F	41–50	23	Private practice	four	< 10%	BASMT UKCP
4	F	61	8	NHS clinics	two	< 10%	BASMT BAC UKCP
5	F	61+	18+	NHS clinics, Private agency	two	< 10%	BASMT UKCP
6	F	41–50	12	Private practice	—	< 10%	BASMT UKCP

order to reduce to a minimum the setting of an agenda and biasing the focus of the analysis (Rennie *et al.*, 1988).

Ethical considerations

Because of the nature of the subject area, namely sexuality and disability, and the need to maintain confidentiality of both participants and any client information that might arise in the course of the interview, particular attention was paid to ethical issues. Before the distribution of the questionnaires the covering letter and questionnaire were submitted to the relevant authority within the BASMT for their approval to contact members and interview them. The procedure for recording the interview and the subsequent transcription were explained to the participants before the interview. A brief background of both the researcher and the general area of the research was also given, along with an assurance that the tapes would be destroyed once the research was completed. Participants' names and any references to places or people have, in accordance with the above, been altered or removed to reduce to a minimum the possibility of identification. All participants signed a consent form.

At the end of the interview participants were debriefed, ensuring that they were able to raise any questions or concerns that had been generated by the interview. Details were given of The Association to Aid The Sexual and Personal Relationships of People with a Disability (SPOD), an agency specializing in referral to counsellors and the dissemination of information around sexuality and disability, in addition to offering advice and support to professionals. This was considered sufficient

information should any unresolved issues arise, given that all the participants were experienced professional therapists with ongoing access to supervisors and other support systems.

Results

Grounded theory employs a coding procedure that aims to use a systematic analytical structure by which a unique theory that is 'grounded' in the data itself can be constructed. The coding process is built up in three stages which are interrelated, namely Open Coding, Axial Coding and Selective Coding (Strauss & Corbin, 1990). These stages are described below as they apply to the data, and the researcher's internal reflective processing of these data is illustrated with examples from them.

Open Coding

Strauss & Corbin (1990) describe Open Coding as "the process of breaking down, conceptualising and categorising" data. Each of the six interviews were broken down and labelled, initially into descriptive units of meaning or concepts, aiming to represent the reported experience of working with disabled clients. An example of this process is illustrated by the following passage:

> R Well I think it was a very big factor. Yeah, I think it was, you know the first thought is, oh dear, what am I going to do here? You know, how am I going to approach this situation? Can I ask them standard sort of questions? You know, say about sexual functioning or issues that go on between them. How do they make love? Can I ask those kind of questions or do I have to kind of footsy around it, pretend—pretend it doesn't happen? You know. And I think a very genuine sort of embarrassment, you know like, like things are obviously bound to be somewhat different here, particularly the man where his—he didn't have arms and therefore you know the mind boggled in a sense.

This passage illustrates the reflective process that the interviewees reported when asked about their first meeting with a physically disabled client. Following Strauss and Corbin's (1990) approach the passage was read through, and any thoughts and ideas that arose for the researcher were noted and written down alongside the text, 'memoed' for ongoing analysis. As each concept or distinct unit of meaning which had relevance to the therapist's experience was identified, it was labelled so as to represent the meaning that was either explicit or implicit within the context of the phrase, sentence or paragraph, where appropriate using the participant's own words. "Yeah, I think it was, you know the first thought is, oh dear, what am I going to do here? You know, how am I going to approach this situation?". This seems to express a sense of anxiety or uncertainty about what to do when faced with an obviously physically disabled client and as such it was labelled *feeling uncertain what to do with disabled client*. The therapist then proceeds to ask, "Can I ask them standard sort of

questions? You know, say about sexual functioning or issues that go on between them. How do they make love?" illustrating *embarrassment asking questions about sexuality normally asked of clients*. The ongoing questioning about what to do is explored in "Can I ask those kind of questions or do I have to kind of footsy around it, pretend—pretend it doesn't happen?" thus suggesting one 'way out' is to 'footsy around' or evade questions about the sexuality of the client. This is labelled *feeling a need to evade asking direct questions about sex and intimacy*. This is elaborated by the therapist's sense of embarrassment around the belief that something very different is likely to be happening sexually as a result of one of the couple being disabled. Hence: "And I think a very genuine sort of embarrassment you know like, like things are obviously bound to be somewhat different here, particularly the man where his—he didn't have arms and therefore you know the mind boggled in a sense"—*a sense of unknowing embarrassment about what disabled clients do sexually.*

From this section the following concept labels were created for the identified units of meaning:

- *Feeling uncertain what to do with disabled client.*
- *Embarrassment asking questions about sexuality normally asked of clients.*
- *Feeling a need to evade asking direct questions about sex and intimacy.*
- *A sense of unknowing embarrassment about what disabled clients do sexually.*

Open Coded categories

The next stage of analysis involved the clustering of concepts into Open Coded categories. While still maintaining the original core meaning within the data (or as Glasser & Strauss (1967) refer to it, what 'fits' the data) the researcher brings to the data an understanding and knowledge of the constructive process of the interviews to develop categories which both represent or 'fit' that which emerges as a cluster of concepts.

The following illustrates the creation of the Open Coded Category: *Anxiety raising sex and disability with disabled clients*.

> Yes, I think so. Not wanting to upset anybody. I... probably by being like that more likely to be upsetting. Then I am aware of that now. Well, I was probably aware of it then but ... not knowing what to do about it.

Concept label: *Awareness of fear of upsetting clients by raising disability inappropriately.*

> I skated round the issues. It was the wife. She had some sort of muscular dystrophy and I think I got sort of hooked in, as they did. Let's sort of talk about it but not talk about it and her fear was that her husband really didn't fancy her because of her disability, because of the way she looked.

Concept label: *Avoidance of raising issues of disability and sexual attraction.*

> Yes. Because it's interesting. I don't—I mean, I think I'm quite a confrontative therapist when necessary, so, I don't, I think I can confront

TABLE II. Sample clustering of concept labels into open coded category

Anxiety raising sex and disability with disabled clients
• Feeling a need to evade asking direct questions about sex and intimacy
• A sense of unknowing embarrassment about what disabled clients do sexually
• Questioning possible voyeurism of talking about sex and intimacy where a person is disabled
• Avoidance of raising issues of disability and sexual attraction
• Need for safety in the therapeutic relationship before talking about disability and sex
• Awareness of fear of upsetting clients by raising disability inappropriately
• More reticence with disabled clients
• More nervous not knowing what is appropriate to say
• Difficulty finding words to ask what goes on sexually
• Lacking confidence being confrontative with disabled clients

gently but firmly and I think probably what happens in this situation is that I am less confident about being confrontative.

Concept label: Lacking confidence being confrontative with disabled clients.

These concept labels, with several others, (see Table II) seemed to form a cluster of labelled concepts that was given the category name *Anxiety asking disabled clients about sex and disability*. A complete list of Open Coded Categories and sample concepts is shown in Table III.

Axial Coding

The Axial Coding stage is the process whereby the categories are re-examined by comparing the dynamic relationships that emerge from the different combinations of categories while reflecting upon how this sheds light upon the underlying experience of sex and relationship therapists working with physically disabled clients.

Connections and relationships between categories were explored using the model outlined by Strauss & Corbin (1990) whereby each category is specified "in terms of the conditions that give rise to it, the context in which it is embedded, the strategies by which it is handled and the consequences of these strategies".

To illustrate the researcher's 'meaning-making process' the following category has been selected as an example: *De-skilling experienced by perceived 'otherness' of disabled clients' sexuality* (see also Table IV).

The causal condition which seems to have given rise to therapists experiencing de-skilling was the *perception of disabled clients' lives as outside the therapists' frame of reference* combined with the *perception of disabled clients' sexuality as different*. These conditions taken together gave rise to *anxiety raising sex and disability with disabled clients*. This is despite the fact that sexuality in particular is the very area that, as sexual and relationship therapists, they would normally take as routine. This was seen to be set within the context of the therapeutic relationship, where the therapist experienced a *strong emotional response to disabled clients' lives*. These processes working together influenced the therapists' interventions, which were categorized as

TABLE III. Summary of Open Coded categories and sample concepts

Open Coded categories	Sample of concepts
Sense of skills inadequacy with disabled clients	• Questioning the value of skills • Feeling uncertain what to do with disabled client • Feeling discomfort with physical aspects of disability
Anxiety raising sex and disability with disabled clients	• Lacking confidence being confrontative with disabled clients • Avoidance of raising issues of disability and sexual attraction • Feeling a need to evade asking direct questions about sex and intimacy
Perception of disabled clients' lives as outside the therapist's frame of reference	• Sense that they don't quite fit in • Sense that disabled client's frame of reference is unknown to therapist • Feeling something like nervous amusement at sudden imagining that sex is going to be strange
Perceiving disabled clients as dependent	• Disabled client visually perceived as child-like • Attributing client's possessiveness to the disability • Feeling that he thought we should be on his side due to his disability
Shifting definitions of disability	• Questioning whether sick and ill people are disabled • Disability seen as a label independent of illness • Disability label seen firstly as mental health problems
Managing the client by splitting disability, sex and relationships	• Focusing on couple relationship and deal separately with disability • Sense that clients enjoy being man and woman, separating out disability • Dealing with disability by pretending it isn't there
Placing extra value on expert support with disabled clients	• Valuing team support as confidence raising with disabled clients • Increased supervision needs with disabled clients • Sense of needing medical support with disabled clients
Sense of safety induced by structured context	• Preparation use of questionnaire deflects initial shock of disability • Sense that the research context places illness 'out there' • Reflecting on desensitising effects of a Health Centre
Contact as discomfort reduction factor with disabled clients	• Initial apprehension disappears over time • Working with a disabled colleague has lessened my embarrassment • Relationship with a terminally ill person changed my approach
Perception of disabled clients' sexuality as 'different'	• Disabled clients don't quite fit in • Curiosity about what sex with a disabled man would be like • Having no arms and hands sits further outside than others
Sense of disability as loss	• Perception of disability being about lost expectations • It feels like working with bereavement • Sense that issues no different from other clients' losses
Empathic deficit with choice of disabled client as sexual partner	• Perception that disabled clients seeking sexual relationships will be especially difficult • Theorising that partners of disabled women may seek sex outside the relationship • Imagining sex with this man might be abnormal or weird
Strong emotional response to disabled clients' lives	• Awareness of wanting to take care of and feeling sorry for the client • Expressing feelings of anger on behalf of disabled clients' experiences • More emotionally involved and scared
Perception of altered developmental paths in disabled clients	• Perceived special status for disabled client because of academic skills • Focusing on intellect as the only 'level playing field' available to disabled people • Belief that those disabled later in life are likely to have a normal sex life

TABLE IV. Example of inductive process of Axial Coding

Process stage	Open Coded categories	Axial Code
Causal condition	Perception of disabled clients' lives as outside therapist's frame of reference Disabled people's sexuality is beyond the known	De-skilling experienced by perceived 'otherness' of disabled client's sexuality
Phenomenon	Anxiety raising sex and disability with disabled clients	
Context	Stronger emotional response to disabled clients' lives	
	Action/intervention disability, sex and relationships	Managing the client by splitting
Consequences	Placing extra value on expert support with disabled clients	

managing the client by splitting disability, sex and relationships. The sense of being able to cope with clients' presenting issues and remain professionally appropriate had the consequence of *placing extra value on expert support with disabled clients*. This support seemed to consist of supervision as well as team support for those who worked in more formal medical settings. Three additional Axial Codes emerged using a similar methodology as above as illustrated in Table V.

Selective Coding

Selective coding is the process by which a central theme or category is identified and then related back to other categories in order to clarify and expand the meaning while still maintaining and validating a close relationship to the data. This systematic process is similar to the Axial Coding but takes place at a higher level.

In accordance with Strauss & Corbin (1990) the initial phase of this process is to construct a story line which is "a descriptive narrative about the central phenomena of the study' (p. 116). The following narrative is illustrative of this process:

> This research sought to explore the experience of six female sex and relationship therapists working with physically disabled clients. Although the therapists stated they had had few such clients, during the interviews several recalled clients whom they had not thought of as disabled. The meaning of 'disabled' itself shifted during and between interviews. Most experienced some degree of anxiety and nervousness when presented with physically disabled or chronically ill clients.
>
> Most therapists talked in terms embued with strong feelings about these clients and/or their 'disability'. They felt that their initially reticence of disabled clients decreased over time and with experience and while in

TABLE V. The relationship between Axial Codes and Open Coded categories

Open Coded categories	Axial Codes
A sense of skills inadequacy Anxiety raising sex and disability with disabled clients Placing extra value on expert support with disabled clients Perception of disabled clients' lives as outside the therapist's frame of reference	De-skilling experienced by perceived 'otherness' of disabled client's sexuality
Managing the client by splitting disability, sex and relationships Sense of safety induced by structured context	Separating disability from the person
Perceiving disabled clients as dependent Perception of altered developmental paths in disabled clients Contact as discomfort reduction factor with disabled clients Perception of disabled clients' sexuality as 'different'	Adjusting to atypical physical presence of disabled client
Sense of disability as loss Empathic deficit with choice of disabled client as sexual partner Strong emotional response to disabled clients' lives	Experiencing disability in clients as an embodiment of loss

retrospect they found it a learning experience, they may not have chosen it. They reported feelings of hopelessness and despair with some disabled clients who they thought had unrealistic expectations.

Most therapists adopted a treatment process that split sex, the relationship and disability and saw this as a useful way of coping with what they saw as a complex number of issues. However, some were aware that this may represent a way of coping with their own feelings about the client's disability and their perceptions of it. There was a general sense in which disabled clients' disabilities were outside the norm, even given the wide range of clients they already saw as sexual and relationship therapists. This seemed to centre around the 'otherness' of what clients represented and what they could offer in an intimate sexual relationship.

Most therapists interviewed found the process of the interview stimulated areas of thought and feeling about disabled clients and disability in general that they had not clearly addressed before.

After re-evaluating the original raw interview data, the coding process and the story line, a core category emerged which remained in accord with the four Axial Codes and is presented in Fig.1.

A tension evoked by the perceived 'otherness' of the disabled client, manifesting in a body / person dichotomy and mediated by distancing and exposure experience

FIG. 1. Core category.

The following examples illustrate the process of relating the core category and the Axial Coded category: *Separating the disability from the person.* One aspect of the therapists' experience was *Managing the client by splitting disability, sex and relationships*. For instance, looking at disability not as part of the person, the therapist said of the couple "we looked at disability almost as a concept". This was a conscious decision as indicated by "I try and do it like we've got three clients—his needs, her needs and the needs of the disability". While this splitting was perceived as a positive management intervention it also tended to 'distance' the therapist. The splitting off was sometimes overtly about distancing, as in "I think my way of dealing with disability is to perhaps pretend it isn't there". For some therapists splitting had already taken place at assessment "so it was presented to me as a relationship difficulty". However, this left the therapist feeling that when the client did mention the disability "she seemed very relieved and then I felt I should have done more of this", which offered some indication that experience and exposure might alter the approach.

A second illustration of the process of relating the core category to the Axial Category was *adjusting to the atypical physical presence of disabled client*. As therapists saw few disabled clients, irrespective of their definition of disabled, the initial impact of physical difference or 'otherness' was quite strong and this often activated *perceiving disabled clients as dependent*. For instance discomfort when "it was very difficult for her to get into the consulting room" and "I said goodbye and turned away and of course she couldn't reach the door". But over time the therapist said *"I got used to that ... eventually, the disability wasn't even there between the two of us"*. The physical difference made a stronger impact upon some therapists "so he had what we tend to call flippers on the end of his shoulders and I think his legs were pretty OK". The visible physical presence added to therapists' *perception of disabled clients sexuality as 'different'* and fantasies around what disabled people 'do' sexually became problematic for therapists. In supervision an idea that the therapist was experiencing similar thoughts to those the partner might have originally experienced—"what would it be like to have sex with this guy ?"—was one way to deal with thoughts about the physical 'difference'. Adjustment also took place when the therapist, perceiving the physical limitation of the impairment, had to adapt the programme to suit: "doing sensate focus was very difficult because it was so uncomfortable and the

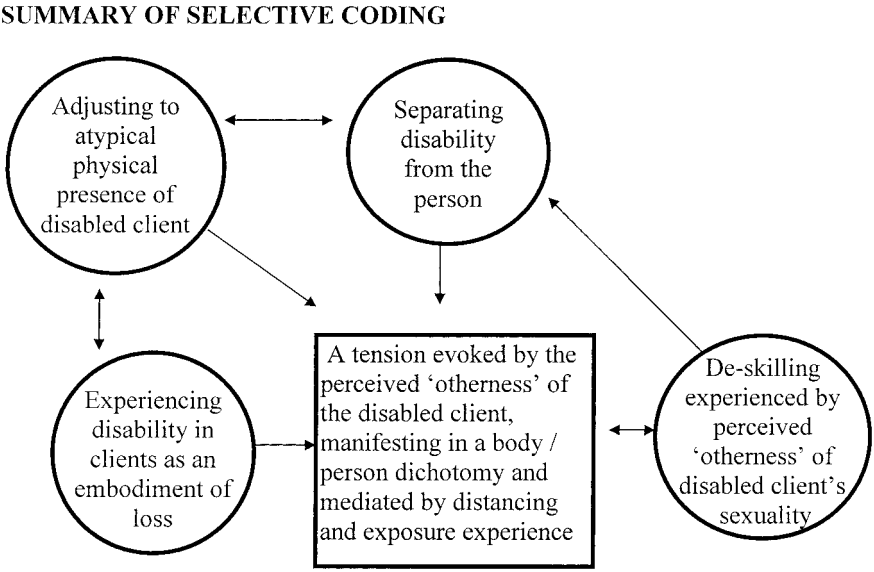

FIG. 2. Relationship between core category and Axial Codes.

programme was very much tailor-made to her". However, there was concurrently a splitting of sex from disability, "But really we talked, we focused much more on the illness than on the sexuality".

Fig. 2 illustrates the dynamic relationship between the core category and the four Axial Codes. It attempts show how splitting seems to arise in relation to the 'otherness' and 'atypical presence' of a disabled client via various perceptions of difference, not least body and sexuality. The perception of disability itself as the embodiment of loss, and dealing with this in the context of sexuality and relationships, also feeds into the core sense of tension. All these produce, and are a result of, a discomfort with otherness and the de-skilling impact upon the therapist. Mediating this is the process of adjustment to a disabled client that may arise through personal or professional experience and act in various ways to lessen the tension.

Discussion

This study sought to explore the experiences of sexual and relationship therapists working with physically disabled clients. From the data, a core dynamic emerged for the therapists interviewed which suggested that there was a splitting resulting from a tension which related to the therapists' awareness of disability and a difficulty in integrating the 'body' of the disabled client and their 'person'. The impact of this was mediated by two main processes: a distancing of the 'self' within the therapeutic relationship, or managing the discomfort by the use of coping strategies gained either through professional experience of working with disabled clients or from

personal experience of colleagues, family or friends with a disability or chronic illness.

While sexuality can be a very sensitive subject, sexual and relationship therapists are likely to be much less reticent in this area than other counsellors or psychotherapists. However, the same may not be so where disability—of which participants had little actual experience (see Table I)—is concerned. It is interesting in the light of the ongoing debate around definitions (Finklestein, 1993) that, during the course of the interview, participants recalled other clients who they began to consider might be defined as physically disabled. There seemed to be evidence of a shifting definition both across and within the interviews, evidenced by one therapist who had a current client with severe chronic arthritis, whom she had not thought of as disabled until the end of the interview.

Unlike the general population studies (Mills *et al.*, 1984; Dunkel-Schetter & Wortman, 1982; Goffman, 1963; Davies, 1961) this study did not support the idea that therapists actively avoided disabled clients. However, with the emergence of categories such as *sense of skills inadequacy with disabled clients* and *perception of disabled clients' lives as outside the therapist's frame of reference* there was a sense in which participants' actual reported experience of disabled clients was one of ambivalence. As reflected in the core category it was felt that the very lack of exposure to this client group meant that the important aspect of learning by experience was missing "We've had to learn by experience. You know it isn't as if one is given any training about this. So you learn by seeing your first client. You know, you don't learn as you might do in another areas."

While all participants were highly experienced and some were supervisors and/or teachers in sexual and relationship therapy, this offered an opportunity to explore the experience of therapists who are perhaps opinion formers and practitioners. But by interviewing highly experienced, accredited city-based therapists a possible difficulty arises. Does their location, method of training and working, often within a medical setting, suggest that the splitting of body/person may be a feature of the biomedical or behavioural approach rather than a distinct reaction to physical disability *per se* in the wider counsellor/psychotherapeutic community? However, while all participant therapists had trained within a major teaching hospital, most were already practising counsellors or psychotherapists before their sexual and relationship training. A further concern is that the sample was all white, British and able-bodied and their disabled clients were also predominantly white and British, this despite the multicultural communities in which most of the clinics were based.

The use of 'memoing' (Strauss & Corbin, 1990) was particularly useful in the process of attempting to represent the qualitative experience of the participants in the data by analysing the researcher's own thoughts and feelings as much as possible before, during and after the interview process. Before the interviews consideration was given to the possible effect of the researcher being visibly physically disabled. Despite 'difference' being a major theme throughout the interviews, the difference of a male disabled researcher interviewing female able-bodied therapists was a dynamic that few elaborated upon, in spite of attempts at permission-giving by the

researcher, who raised it towards the end of the interview. This may reflect one of the major categories, *anxiety raising sex and disability with disabled clients*. However, it may also reflect the 'splitting off' of disability by some therapists, who managed the disabled client by separating the person from the disability. Hence the interviewer may not be seen as both disabled and a researcher/practitioner colleague. This may reflect how the therapist thinks the client would ideally wish to be seen: "She doesn't always have to have her head in being a disabled woman because we look at that separately she can just be a woman".

Most participants expressed a view that they were too inexperienced with disability to be of value in the research. Therapists found it difficult to stay with their own subjective experience and tended to present case studies or report the experience of clients themselves. This may reflect sexual and relationship therapists' style of working which might be different for other types of counselling or psychotherapy. It may also reflect supervision styles that focus upon client material, where some or all of the presenting problem is seen in terms of either the dyadic couple relationship or a biomedical dysfunction model.

Looking back at the 'self-interview', one marked difference between participants and researcher/therapist was the initial reaction to a physically disabled client. First, the researcher had seen many more disabled clients than the participants and, second, having a disability himself there was no sense in which the disabled client was part of some 'otherness' or difference. Most therapists initially saw the disabled client as a challenge and outside their frame of reference; the researcher as therapist, on the other hand, was initially more concerned about issues such as the client's identification with the therapist and if and how being part of a disadvantaged and/or marginalized group within society, had an effect upon the sexual and personal relationships of the client and in the therapeutic relationship.

It is perhaps not surprising that the core dynamic should feature a difficulty which reflects a dualist approach. The person and the body as one holistic entity is not something that sits easily with the positivist tradition. In a paper entitled 'Linking body and mind: reflections on therapeutic processes, ancient and modern', Patricia Hurford (1997), a psychosexual therapist, quotes Paul Martin, a neuro-immunologist: "Our dualist habit of contrasting mind and body as though they were fundamentally different entities is deeply misleading" (Martin,1997). Even when treating what may often be seen as a physiologically based problem, such as erectile dysfunction resulting from diabetes, a holistic approach is required as the psychological aspects are often vital for a person's life and relationships (Harland & Huws, 1997). However, the current trend towards treatment of clients using medication such as Sildenafil can, if not seen in a more holistic context, exacerbate this problem for all clients, not only disabled people.

The limits of this exploratory study also need to be considered. The small sample size suggests that the 'model' generated may only be representative of a distinct cohort of therapists. Even so, this analysis could contribute to ongoing 'theory-building' in this knowledge domain.

The inherent constructivist nature of grounded theory as a research methodology needs to be acknowledged (Henwood & Pidgeon, 1995). While the

'self-interview' conducted early in the research process attempted to address possible agenda biases this researcher might have that could influence the data analysis, it cannot be denied that the model generated is this researcher's construction, from his position as a physically disabled therapist; by its nature must be viewed as one possible representation of these participants' constructions of their experience. Yet as mentioned above, this does not detract from the fact that this exploratory study can inform future broader-based studies.

This study has for reasons mentioned used grounded theory; however, there is a need for a wide range of methodologies both qualitative and quantitative to build upon this beginning. Clearly the low number of disabled clients seen by the participants needs further investigation and a survey aimed at gaining quantitative data of both service provision and 'up-take' by disabled people would prove useful. While there has been some research on the impact of health professionals' own values on sexuality and disabled clients (Wolfe, 1997) it has often focused on learning disabled clients and carers rather than physically disabled clients and psychological services.

Given the emphasis placed by participants on supervision and expert support when seeing disabled clients, an investigation into how the issue of disability is addressed in training and supervision and how far training courses and employment are open to counsellors and therapists who are themselves disabled is an area needing more research.

Finally, perhaps one of the critical areas requiring further research is disabled people's own experience of counselling and psychotherapy, particularly in the area of sexuality and relationship therapy. This would provide a view from 'the other side' of the therapeutic relationship, of which little has been written.

Overall, this research has attempted to highlight an important dynamic stemming from the tendency towards splitting between the 'otherness' as represented by a 'different' body and the personhood of the client. It suggests also that, rather than ghettoizing by inferring that only disabled people can empathize sufficiently to offer therapy to disabled people, facilitating professionals and others who work with difference is likely to prove the most fruitful way forward. Here Rogers' definition of empathy may be most apt in the light of the above: "being empathic, is to perceive the internal frame of reference of another with accuracy, and with the emotional components and meanings which pertain thereto, as if one were the other person, but without ever loosing the 'as if ' condition" (1959: 210).

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